Your Personal Health History

Name: _____ Date: _____

Address: _____ City/ Postal code: _____

Home Phone: _____ Work Phone: _____ Occupation: _____

Birth date: _____ Marital Status_____

Spouse's name: _____ Spouse's Occupation: _____

Children's Names & Ages: _____

_____

Previous Chiropractic Care: ___Yes ___No When? _____ Where? _____

Reason for ending care? _____

Were X-Rays of your Spine taken? __yes __no if not, would you like to have spinal x-rays taken to evaluate your current

state of spinal integrity? __Yes __No__ how did you hear about our office? _____

Email address for correspondence_____

About Your Health

The human body is designed to be healthy. Throughout life, events occur which damage your health expression. This form will help uncover the layers of damage, primarily to your nervous system, which have resulted in less than optimum health. The science of Chiropractic is based on the location and correction of Vertebral Subluxations. These misalignments in your spine are caused by any stress to which your body cannot adapt. These stresses may be physical, chemical or emotional in nature. Following your chiropractic examination, we will outline a course of care to allow your body to begin correcting these layers of damage so you can recover your natural, innate health potential.

Loss of Wellness: (Birth and Early Childhood)

Physical Stress

Complications during *your* mother's pregnancy:_____
Ultrasound during pregnancy? ___yes ___No Complications during delivery?_____
Location of your birth: _____ hospital _____ Birthing center _____ Home
Birth Intervention: _____ Forceps _____Vacuum _____C-Section (emergency or planned?) _____
Please recall any early childhood falls, injuries, impacts:_____
_____
Were you tossed, yanked? shaken?_____
Childhood auto accidents: _____Other traumas:_____
_____
_____

Childhood Chemical Stress

Did your mother smoke / drink / take any medication during pregnancy?_____
Was your birth induced?_____ Was your mother drugged? _____
Childhood illnesses:_____
Were you vaccinated:_____ Medicated:_____Any Surgeries:_____
Other medical trauma:_____
Were you breast-fed?_____ How early were solids introduced?_____ Food allergies?_____

Childhood Emotional Stress

Was your childhood a happy one?_____

Loss of Whole Body Health: (Early Childhood to Present)

Physical Stress

Circle any sport you played: Soccer, Football, Wrestling, Baseball, Basketball, Gymnastics, Cheerleading, Martial Arts, Other_____ How long?_____
Did you have any impacts, falls or jolts which may have injured your spine?_____
Do you recall bike, skating, tree climbing injuries or others?_____
Any auto accidents?_____
During the day you: ___sit ___stand ___walk ___lift ___drive ___do desk work ___phone work
Do you exercise? ____yes ____no What type and how often?_____
Have you had any surgeries as an adult? _____
Sleep position:_____

Chemical Stress

Diet: *Please check all that apply to you:*

___Fast Food Restaurants	___ Artificial Sweeteners	___Vegetarian
___dairy products	___Cigarettes how much_____	___Coffee
___meats	___Soda	___Alcohol
___non organic vegetables	___Sugar	___Recreational Drugs

Medications: Name of Drug Length of time taking it What do you take it for?

Does your home or work environment expose you to any chemical stresses? _____

Emotional Stress

Would you consider your life to be "in order" at this time?_____
Have you undergone any great change in the last year?_____
Have you had any great losses in the past year?_____
Are there any significant fears present in your life?_____
Are you satisfied with your job/ relationships/ achievements of goals?_____

Do you experience currently:

___Massage	___Playtime	___Work Stress
___Energy Work	___Martial Arts	___Home Stress
___Yoga	___Meditation	___Prayer

Present State of Health: Presenting Symptoms

Finally the years of continuing damage showed up as acute or chronic symptoms.

Present complaint :_____ When did this pain or problem start?_____
Describe the symptom: _____
What aggravates it? _____Is it worse at a certain time of day?_____
Does it interfere with: work____sleep___ routine___ other_____ Is it getting worse?_____
What activities lessen the pain? _____Have you seen other doctors for this?____

Other symptoms/ conditions:

__headaches	__asthma	__allergies	__fainting	__fever
__neck pain	__pins & needles	__chest pains	__loss of smell	__restricted motion
__insomnia	__numbness	__breath shortness	__loss of taste	__stiff neck
__irritability	__nervousness	__cold extremities	__stomach upsets	__cold sweats
__depression	__fatigue	__back pain	__diarrhea	__memory loss
__dizziness	__light sensitive	__ears infections	__constipation	

Is there anything else you would like us to know about to help us better understand and relate to your current state of health? _____

_____

I *attest that the above information is true and complete to the best of my knowledge. I further give* ***Dr. Laura Gravelle*** *permission to perform an exam on me to determine proper course of chiropractic treatment.*

_____