

Wellspring Chiropractic

SERVING THE COMMUNITY FOR OVER 25 YEARS

PERSONAL HEALTH HISTORY

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Cell phone: _____ Other: _____

Email Address: _____

Date of Birth: _____ Age: _____ Gender: _____ Occupation: _____

Marital Status: Single Partnered Married Separated Divorced Widowed # of children: _____

In case of Emergency, Contact: _____ Relationship: _____ phone: _____

Whom may we thank for referring you to Wellspring Chiropractic? _____

Your body is designed to be healthy.

Throughout life, experiences and events occur which may negatively impact your body's expression of health. Chiropractic serves to locate and release nerve interference and tension patterns which are being stored in your body; this allows for a greater expression of health.

Please thoroughly fill out the following information in order to help us understand your current state of health.

- Reason for seeking Chiropractic Care: (please mark all that apply)

To experience a new level of health and healing To be more connected to my body

To relieve my pain I'm not sure

Other: _____

- Do you currently have any health concerns? Yes No Please explain:

- How has the above affected your life? _____

- What do you hope to gain from the care here at Wellspring Chiropractic? _____

- Have you received Chiropractic Care in the past? Yes No

Date of last adjustment: _____ How long were you under care for: _____

Reason for ending care: _____

- Please briefly describe your daily routine, including meals and snacks: _____

- What are your daily exercise habits? _____

- What are your current play/recreation activities? _____
- What is your level of commitment to yourself, your health and your wellbeing: High Medium Low
- How would you rate your current health? Poor Fair Average Good Excellent
- How would you describe your family's health? Poor Fair Average Good Excellent
- Are you healthier now than you were 5 years ago? ___ Yes ___ No Why? _____
- Do you know the health history of your birth? ___ Yes ___ No
 - Were you born: ___ Home birth ___ Hospital birth ___ Adopted ___ Other
 - Was your birth: ___ Vaginal birth ___ Cesarean section ___ Forceps ___ Suction
 - Was medical intervention used during your birth? ___ Yes ___ No _____
- Are you currently receiving medical attention and if so, for what? _____

- Please list ALL medications you are currently taking (prescription and non-prescription)

The following are some of the major stressors, which can contribute to interference and tension in your body.
Please check all that apply (or have applied) to you.

Physical Stressors

- Birth Trauma
- Slip/Falls
- Car Accidents
- Sports Injuries
- Physical Abuse
- Heavy Physical Labor
- Poor Posture
- Excessive Computer Use
- Prolonged Driving/Standing
- Repetitive Movements

Emotional Stressors

- Relationships
- Career
- Family
- Finances
- Pace of Life
- Quick Temper
- Holding in Feelings
- Perfectionism
- Procrastination
- Depression

Chemical Stressors

- Environmental
- Smoker
- 2nd Hand Smoke
- Caffeine
- Alcohol
- "Diet/Sugar Free" Food
- Soda Intake
- Prescription Drugs
- Junk Food
- Recreational Drugs

- What do you feel is the primary stress in your life? _____
- What are the 5 healthiest habits you currently choose in your life? _____
- What are the top 5 habits you would like to shift in your life? _____
- Why is your health important to you (i.e. how will your life be better and what will you do once you reach your health goals)? _____
- Is there anything else you would like to share with us? _____

All questions contained in this questionnaire are strictly confidential.