

# Pappas Chiropractic, D.C., P.C.

## Personal and Family Health History

Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Name _____ <small>Please Print      First                      Middle Initial                      Last</small>	Employer _____
Address _____	Name of Primary Insurance _____
City _____ State _____ Zip _____	Spouse/Parent Name _____
Phone (H) _____	Spouse/Parent Employer _____
(W) _____ (C) _____	Spouse/Parent SS# _____ - _____ - _____ DOB _____ / _____ / _____
E-mail _____	Name of Secondary Insurance _____
Date of Birth _____ / _____ / _____ Age _____	Emergency Contact Name _____
Social Security # _____ - _____ - _____	Emergency Contact # _____
Marital Status    S      M      D      W	Referred By: _____

Please List any Children:	Age	Chiropractic care?	Reason:
1.			
2.			
3.			
4.			

You deserve to be healthy. Life is a miracle and so are you. When you were created, you were given all the blue-prints, intelligence, tools, and systems to live an active healthy life. Unfortunately, your health can be interfered with through accidents and challenges that cause a disruption to your health expression. Through your examination and through your lifetime involvement in chiropractic care, we will work to remove these interferences to your natural health expression so that you can live the quality of life you deserve.

1. Was Your Birth Traumatic?	Patient	Spouse	Child 1	Child 2	Child 3	Child 4
Long Delivery?						
Difficult Delivery?						
Forceps?						
Caesarian?						
Breach/cephalic?						
Home Birth?						
Mother given drugs during delivery?						

2. Growth & Development, did you ever once....	Patient	Spouse	Child 1	Child 2	Child 3	Child 4
Learn to care for your spine?						
Fall out of bed?						
Bang your head?						
Breastfed?						
Childhood sickness?						
Have any accidents?						
Have surgery?						
Take drugs?						
Fall while learning to walk?						
Bullied by your siblings?						
Chair pulled out when sitting?						
Fall down the stairs?						
Pulled by your arm?						
Experience other traumas?						

3. Current Health Habits	Patient	Spouse	Child 1	Child 2	Child 3	Child 4
Smoke?						
Drink? (alcoholic beverages)						
Diet? (eat healthy foods)						
Been in accidents?						
Had organs replaced/removed?						
Drugs? Rx or non Rx						
Have teeth problems?						
Have eye problems?						
Have hearing problems?						
Exercise regularly?						
Have sleeping problems?						
Have occupational stress?						
Have physical stress?						
Have mental stress?						
Have hobbies/sports injuries?						

Sleeping posture? (circle one)      side      stomach      back  
 Are you **pregnant**?    Y    N    Due date \_\_\_\_\_  
 Have you seen a Chiropractor before?    Y    N  
    Doctor seen \_\_\_\_\_ Last visit date \_\_\_\_\_  
    Previous issue \_\_\_\_\_  
 Do you have a **pacemaker**?    Y    N  
 Have you ever had any **surgeries**?    Y    N    What and when?  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**MEDICATIONS:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**VITAMINS:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Current Health Condition**

Present Complaint - Reason For Your Visit Today

Major \_\_\_\_\_

Pain or Problem started on \_\_\_\_\_

Pains are:       Sharp       Dull       Constant       Intermittent

What activities aggravate your condition/pain? \_\_\_\_\_

What activities lessen your condition/pain? \_\_\_\_\_

Is condition worse during certain times of the day? \_\_\_\_\_

Is this condition interfering with work? \_\_\_\_\_ Sleep? \_\_\_\_\_ Routine? \_\_\_\_\_ Other? \_\_\_\_\_

Is this condition getting progressively worse? \_\_\_\_\_

Other doctors seen for this condition? \_\_\_\_\_

Any home remedies? \_\_\_\_\_

**Accident Information**

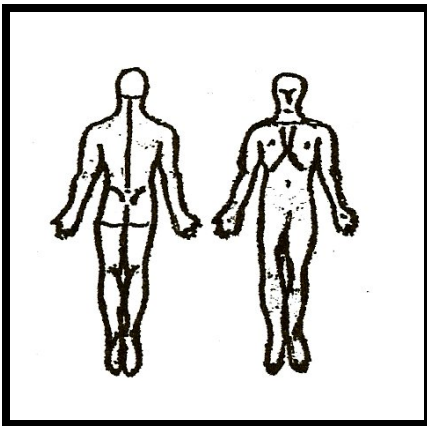
Is condition due to an accident? Y N Date \_\_\_\_\_

Type of accident  Auto     Work     Home     Other

To whom have you made a report of your accident?  Auto Insurance     Employer     Worker Comp     Other

Attorney Name (if applicable) \_\_\_\_\_

**Mark an X on affected areas**



**Other symptoms:**

- Headaches
- Dizziness
- Light Bothers Eyes
- Loss of Memory
- Loss of Taste
- Loss of Smell
- Loss of Balance
- Buzzing in Ear
- Ringing in Ear
- Face Flushed
- Fever
- Fainting
- Cold Sweats
- Depression
- Nervousness
- Fatigue
- Tension
- Neck Pain
- Stiff Neck
- Chest Pains
- Shortness of Breath
- Back Pain
- Sleeping Problem
- Stomach Upset
- Constipation
- Diarrhea
- Irritability
- Cold Hands
- Cold Feet
- Numbness in Fingers
- Numbness in Toes
- Pins & Needles in Arms
- Pins & Needles in Legs
- Other \_\_\_\_\_

**Family Health History:**

	Heart Disease	Arthritis	Cancer	Diabetes	Other _____
Father's Side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mother's Side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Upon the completion of your first visit, you will receive a Chiropractic Report to discuss the different types of Active Life Plans that are available to you. Chiropractic Active Life Plans are designed to help get you feeling better quickly and to help you and your family be as healthy as possible. Please review the explanations of the Chiropractic Active Life Plans prior to your Chiropractic Report appointment so you can choose the level of participation that supports you in reaching all of your health goals.

As a result of my chiropractic care, I would like to **(Please check all that apply)**

- Feel better quickly
- Have a healthier spine
- Have a healthier body by keeping my nerve system healthy
- Live a healthier lifestyle

\_\_\_\_\_  
(Patient/Guardian Signature)