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

**Personal and Family Health History** Date______/______/________

Name_______________________________________________
Please Print First Middle Initial Last

Address_______________________________________________

City__________________________ State_______ Zip___________

Phone (H)_______________________________________________

(W)_______________________(C) ________________________

E-mail_______________________________________________

Date of Birth________/_______/___________ Age_____________

Social Security #___________-____________-________________

Marital Status S M D W

Occupation_______________________________________________

Employer_______________________________________________

Name of Primary insurance________________________________________

Spouse/Parent Name_____________________________________________

Spouse/Parent Employer__________________________________________

Spouse/Parent SS#_________-________-____________DOB____/____/____

Name of Secondary Insurance______________________________________

Emergency Contact Name_________________________________________

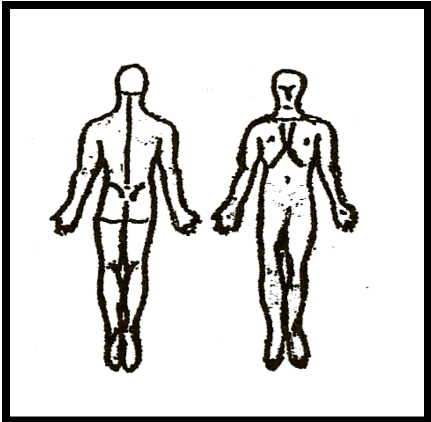
Emergency Contact #____________________________________________

Referred By: ________________________________________________

Name of primary doctor: _________________________________________

| **Current Health Habits** | Patient |
|---|---|
| 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? | |

| **Growth & Development, did you ever once….** | Patient |
|---|---|
| Learn to care for your spine? | |
| Have any accidents? | |
| Have sports injury? | |
| Have surgery? | |
| Take drugs? | |
| Experience other traumas? | |



**Mark an X on affected areas**

**VITAMINS:**

_______________________________________

_______________________________________

**MEDICATIONS:**

_______________________________________

_______________________________________

Sleeping posture? (Circle one) side stomach back

Are you **pregnant**? Y N

Have you seen a Chiropractor before? Y N

___________________ Last visit date____________________ Previous issue____________________

Do you have a **pacemaker**? Y N

Have you ever had any **surgeries**? Y N

What and when?

_____________________________________________________________________________________

_____________________________________________________________________________________

*Current Health Condition*

Reason for Your Visit Today
Major ______________________________________________________________________________________

Pain or Problem started ________________________________________________________________________

**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) ___________________

**Other symptoms:**

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

**Family Health History:**

| | Heart Disease | Arthritis | Cancer | Diabetes | Other _______________ |
|---|---|---|---|---|---|
| Father's Side | ❒ | ❒ | ❒ | ❒ | ❒ |
| Mother's Side | ❒ | ❒ | ❒ | ❒ | ❒ |

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

_______________________________________________
(Patient/Guardian Signature