

# PERSONAL HEALTH HISTORY FORM

Today's Date \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

Parent's names (if you are under 18) \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home phone (\_\_\_\_) \_\_\_\_\_ Business Phone (\_\_\_\_) \_\_\_\_\_

Cell Phone (\_\_\_\_) \_\_\_\_\_ E-mail address \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

SS# \_\_\_\_\_ Emergency contact \_\_\_\_\_

Marital Status S M D W Name of Spouse \_\_\_\_\_

Names and Ages of Children \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

## REASON FOR SEEKING CHIROPRACTIC CARE

What concerns do you feel Chrysalis Chiropractic can address for you?

\_\_\_\_\_  
\_\_\_\_\_

Is this concern affecting your quality of life? (Please circle only those applicable to you)

Work:	Y	N	Recreation:	Y	N	Sleep:	Y	N
School:	Y	N	Walking:	Y	N	Sitting:	Y	N
Exercise/sports	Y	N	Eating:	Y	N	Other:	_____	

Pain or Problem started on \_\_\_\_\_ Pains are:  Sharp  Dull  Constant  Intermittent

Rate your pain on a scale of 1 to 10 – (1 is no pain 10 is the worse pain ever): \_\_\_\_\_

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

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

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

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

Other Doctors seen for this condition \_\_\_\_\_

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

Have you had this pain before? \_\_\_\_\_

If, yes what helped? \_\_\_\_\_

### Other symptoms:

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> Headaches         | <input type="checkbox"/> Face Flushed           | <input type="checkbox"/> Light Bothers Eyes | <input type="checkbox"/> Feet Cold       |
| <input type="checkbox"/> Neck Pain         | <input type="checkbox"/> Neck Stiff             | <input type="checkbox"/> Loss of Memory     | <input type="checkbox"/> Hands Cold      |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Pins & Needles in Legs | <input type="checkbox"/> Ears Ring          | <input type="checkbox"/> Stomach Upset   |
| <input type="checkbox"/> Back Pain         | <input type="checkbox"/> Pins & Needles in Arms | <input type="checkbox"/> Fever              | <input type="checkbox"/> Constipation    |
| <input type="checkbox"/> Nervousness       | <input type="checkbox"/> Numbness in Fingers    | <input type="checkbox"/> Fainting           | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Tension           | <input type="checkbox"/> Numbness in Toes       | <input type="checkbox"/> Cold Sweats        | <input type="checkbox"/> Buzzing in ears |
| <input type="checkbox"/> Irritability      | <input type="checkbox"/> Shortness of Breath    | <input type="checkbox"/> Loss of Smell      |  |
| <input type="checkbox"/> Chest Pains       | <input type="checkbox"/> Fatigue                | <input type="checkbox"/> Loss of Taste      |  |
| <input type="checkbox"/> Dizziness         | <input type="checkbox"/> Depression             | <input type="checkbox"/> Diarrhea           |  |

## HEALTH CARE PRACTITIONER HISTORY

Have you ever received Chiropractic care? Y N With whom \_\_\_\_\_

How long under care? \_\_\_\_\_ Date of last visit: \_\_\_\_\_ Why did you stop? \_\_\_\_\_

Was there a particular health concern for which you consulted the chiropractor?  
\_\_\_\_\_

Have you consulted or do you regularly consult any of the following care providers? (check all that apply)

- Medical Physician       Naturopath       Acupuncturist       Homeopath  
 Massage Therapist       Psychotherapist       Energy Healer       Dentist

Reason why: \_\_\_\_\_

**FOR WOMAN:** Are you pregnant? Y N If pregnant, what is due date? \_\_\_\_\_

Name of OBGYN or Midwife \_\_\_\_\_

Where will you be birthing your baby?  Hospital  Home  Birthing Center  Other \_\_\_\_\_

## HEALTH, WELLNESS AND CHIROPRACTIC CARE

The human body is designed to be healthy. The primary system in the body which coordinates health is the NERVE SYSTEM. The vertebrae, (bones of the spine) surround and protect the delicate NERVE SYSTEM.

Physical, emotional and chemical stresses, common to our contemporary lifestyles, can result in misalignment to the spinal column as well as damage to the nerve system. The result is a condition called Vertebral Subluxation. The Chiropractic Exam/evaluation determines if your spine shows signs of the Vertebral Subluxation process.

Please review and indicate your history of "stresses" (below) so that we can assess their relationship to your present health status and examination findings. We will discuss this during the consultation.

### HISTORY OF PHYSICAL STRESSES (Birth to Present)

**The *birth process* can traumatize a baby's spine and cause *damage to the nerve system*. Please indicate to the best of your recollection where and how you were birthed. (check all that apply) If you do not know, please skip to next question.**

- Home       Natural       Hospital       Caesarian section       Forceps  
 Breech       Cord around neck       Prolonged labor       Drug induced labor       Suction

**The information below will help us to see the types of PHYSICAL stresses that you have been subjected to and how they may relate to your present health status.**

Have you had any accidents related to any of the following? (check all that apply)

- Automobile       Motorcycle       Bicycle       Sports       Playground       Abuse

If yes, please explain how and dates:  
\_\_\_\_\_  
\_\_\_\_\_

Have you ever injured your spine (head, neck, rib/chest area, back, pelvis or hips)? Y N

If yes, please explain how and dates:  
\_\_\_\_\_  
\_\_\_\_\_

Have you ever broken any bones or sprained any part of your body? Y N

If yes, please explain how and dates:  
\_\_\_\_\_  
\_\_\_\_\_

Have you ever been hospitalized? Y N If yes, please explain how and dates:  
\_\_\_\_\_  
\_\_\_\_\_

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## HISTORY OF CHEMICAL STRESSES

Chemical stresses occur during life due to any substance that is breathed, injected, taken by mouth, or placed on the skin that is toxic to the body, (e.g.: food allergies, drug reactions, exposure to chemicals in the air, etc.) The following will give us insight into any exposures you may have had.

Were you vaccinated? Y N If yes, did you have a reaction? Y N If yes, please explain: \_\_\_\_\_

Do you consume any of the following presently?

Coffee/caffeine     Alcohol     Tobacco     Over the counter drugs     Prescribed drugs

Please list all medications (prescribed and over the counter): \_\_\_\_\_

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## HISTORY OF EMOTIONAL STRESSES

It is difficult to separate the emotional stress in our life from the physical response that often occurs. Please indicate if you have experienced any of the emotional stresses:

Childhood Trauma	Y	N	Loss of loved one	Y	N	Abuse	Y	N
Work or School	Y	N	Divorce/separation	Y	N	Financial	Y	N
Lifestyle change	Y	N	Parents divorce	Y	N	Illness	Y	N

## QUALITY OF LIFE

How do you grade your physical health?	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
How do you grade your emotional/mental health?	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
How do you rate your overall "quality of life"?	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor

## EXPECTATIONS

As a result of my Chiropractic Care, I would like to: (Check all that apply)

Feel better quickly                       Have a healthier nerve system  
 Have a healthier spine                       Have optimum health on all levels

*The information I have provided, on this case history form, is true and accurate, to the best of my knowledge. I give Dr. David Capps, DC and/or Dr. Lola Capps, DC permission to render care to me today. This initial visit includes a health history/consultation, chiropractic exam/evaluation, and any initial care that is determined to be clinically necessary and mutually agreed upon.*

Signature \_\_\_\_\_ Today's Date \_\_\_\_\_

Signature of Parent (for minor): \_\_\_\_\_ Today's Date \_\_\_\_\_