



**Patzer Family Chiropractic
Personal and Family Health History**

Date _____

Name _____

Address _____

City _____ State ____ Zip _____

Phone: (H) _____ (W) _____

E-mail _____

Date of Birth _____ (Age _____)

Referred By _____

Previous Chiropractic Care? Y N When? _____

Where? _____ Who? _____

Social Security # _____

Occupation _____

Employer _____

Marital Status S M D W

Spouse's Name _____

Spouse's Date of Birth _____

Number of Children and Ages

Name _____

Age _____

Previous Chiropractic Care?

Yes ___ No ___ Reason _____

Name _____

Age _____

Yes ___ No ___ Reason _____

Name _____

Age _____

Yes ___ No ___ Reason _____

Name _____

Age _____

Yes ___ No ___ Reason _____

You deserve to be healthy. Life is a miracle and so are you. When you were created, you were given all the blueprints, 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.

	Patient	Spouse	Child#1	Child#2	Child #3	Chiropractor's Comments
Circle all that Apply						
1. Was Your Birth Traumatic?						
Long Delivery?	Y	Y	Y	Y	Y	_____
Difficult Delivery?	Y	Y	Y	Y	Y	_____
Forceps?	Y	Y	Y	Y	Y	_____
Caesarian?	Y	Y	Y	Y	Y	_____
Breach/cephalic?	Y	Y	Y	Y	Y	_____
Home birth?	Y	Y	Y	Y	Y	_____
Mother given drugs during delivery?	Y	Y	Y	Y	Y	_____
Induced Labor?	Y	Y	Y	Y	Y	_____
2. Growth and Development						
Did you ever once...						
Learn to care for your spine?	Y	Y	Y	Y	Y	_____
Fall out of bed?	Y	Y	Y	Y	Y	_____
Bang your head?	Y	Y	Y	Y	Y	_____
Breastfeed?	Y	Y	Y	Y	Y	_____
Childhood sickness?	Y	Y	Y	Y	Y	_____
Have any Accidents?	Y	Y	Y	Y	Y	_____
Have Surgery?	Y	Y	Y	Y	Y	_____
Take Drugs?	Y	Y	Y	Y	Y	_____
Fall while learning to walk?	Y	Y	Y	Y	Y	_____
Bullied by your siblings?	Y	Y	Y	Y	Y	_____
Child abuse	Y	Y	Y	Y	Y	_____
Spanking?	Y	Y	Y	Y	Y	_____
Pulled ear/chin?	Y	Y	Y	Y	Y	_____
Other	Y	Y	Y	Y	Y	_____
Chair pulled out when sitting?	Y	Y	Y	Y	Y	_____
Fall down the stairs?	Y	Y	Y	Y	Y	_____
Pulled by your arm?	Y	Y	Y	Y	Y	_____
Experience other traumas?	Y	Y	Y	Y	Y	_____

3. Current Health Habits

Did/do you...

Smoke? Y Y Y Y Y _____
 Drink? Y Y Y Y Y _____

	Patient	Spouse	Child#1	Child#2	Child #3	Chiropractor's Comments
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Circle all that Apply

Diet (do you eat healthy foods?)	<u>Y</u>	<u>Y</u>	<u>Y</u>	<u>Y</u>	<u>Y</u>	_____
Have you been in accidents?	<u>Y</u>	<u>Y</u>	<u>Y</u>	<u>Y</u>	<u>Y</u>	_____
Drugs? (Prescriptive or Non-Prescriptive)	<u>Y</u>	<u>Y</u>	<u>Y</u>	<u>Y</u>	<u>Y</u>	_____
Have Teeth Problems?	<u>Y</u>	<u>Y</u>	<u>Y</u>	<u>Y</u>	<u>Y</u>	_____
Have Eye Problems?	<u>Y</u>	<u>Y</u>	<u>Y</u>	<u>Y</u>	<u>Y</u>	_____
Have Hearing Problems?	<u>Y</u>	<u>Y</u>	<u>Y</u>	<u>Y</u>	<u>Y</u>	_____
Exercise regularly?	<u>Y</u>	<u>Y</u>	<u>Y</u>	<u>Y</u>	<u>Y</u>	_____
Have sleeping problems? (nightmares)?	<u>Y</u>	<u>Y</u>	<u>Y</u>	<u>Y</u>	<u>Y</u>	_____
Have occupational stress?	<u>Y</u>	<u>Y</u>	<u>Y</u>	<u>Y</u>	<u>Y</u>	_____
Have physical stress?	<u>Y</u>	<u>Y</u>	<u>Y</u>	<u>Y</u>	<u>Y</u>	_____
Have mental stress?	<u>Y</u>	<u>Y</u>	<u>Y</u>	<u>Y</u>	<u>Y</u>	_____
Have hobbies/sports injuries?	<u>Y</u>	<u>Y</u>	<u>Y</u>	<u>Y</u>	<u>Y</u>	_____
Sleeping posture – side–stomach–back	_____	_____	_____	_____	_____	_____

Current Health Condition

Present Complaint (be brief) 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? _____

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 Ear |
| <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 | |

Have you been under drug and medical care? _____

What medications are you taking? _____

How Long? _____ Have you had surgery? Y N What? _____ When? _____

What side effects have you experienced from the drugs and surgery? _____

Is there a family history of:

	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 Active Life Plan Explanation Sheet 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, my health goals are to

Please check all that apply

- | | |
|--|---|
| <input type="checkbox"/> Feel better quickly/pain relief | <input type="checkbox"/> Have a healthier body by keeping my nerve system healthy |
| <input type="checkbox"/> Have a healthier spine | <input type="checkbox"/> Live a healthier lifestyle |

Signature

Date



**Patzer Family Chiropractic
Pediatric Health History**

Date _____ Phone Number _____
Patient Name _____ Preferred Name _____
Parents/Guardian Names _____
Address _____ Patients date for birth _____ Age _____
City _____ State _____ Zip _____ Sex ___ M ___ F S.S.# _____
Guardian's E-mail _____ Previous Chiropractic Care? Y N When _____
Referred by _____ Where? _____ Who? _____

Please check reasons for pursuing chiropractic care for your child

- She/He is continuing ongoing care from another chiropractor
- I recently had spine checked and I see the value in getting my child checked.
- I'm concerned about his/her health and I am looking for answers.
- She/He has a specific condition that concerns me.(briefly explain) _____
- I want to improve my child's immune function.
- Wellness

In order for us to better understand your child's current level of health, please check any of the following body signals which your child has or has had previously:

- Headaches Postural Asthma Allergies Ear infection
- Scoliosis ADD/ADH PDD/Autism Seizures Growing Pains
- Back Pains Car accident Digestive Problems Frequent Colds
- Sinus Problems Bedwetting Colic

Other: _____

List Prescription and Over The Counter Medications Now Taken:

Known Allergies: _____

Number of doses of Antibiotics Your Child has Taken:

During the past 6 months: _____

Total during his/her lifetime: _____

List reasons: _____

Number of doses of other Prescription Medications Taken:

During the past 6 months: _____

Total during his/her lifetime: _____

List reasons: _____

Prenatal History

Adopted? ___ Yes ___ No

Complications during pregnancy? ___ Yes ___ No

List: _____

Ultrasounds during pregnancy? ___ Yes ___ No Number: _____

Medications/drugs/caffeine during pregnancy? ___ Yes ___ No

List: _____

Cigarette / Alcohol use during pregnancy? ___ Yes ___ No

Location of Birth: ___ Hospital ___ Birthing Center ___ Home

Birth Intervention

___ Mother induced ___ Mother medicated (Pitocin, etc) ___ Caesarian Section

___ Forceps ___ Vacuum extracted

___ Baby given medications after delivery: _____

Complications during delivery? ___ Yes ___ No List: _____

Genetic disorders or disabilities? ___ Yes ___ No List: _____

Breast Fed? ___ Yes ___ No How long? _____

Formula Fed? ___ Yes ___ No How long? _____

Food Allergies or Intolerances? _____

According to the National Safety Council, approximately 50% of children head fall first from a high place during the first year of life. (i.e., a bed, changing table, down stairs, etc.)

Was this the case with your child? ___ Yes ___ No

List: _____

Is/Has your child been involved in any high impact or contact type sports? (i.e., soccer, football, gymnastics, hockey, baseball, cheerleading, martial arts, etc.) ___ Yes ___ No

List: _____

Has your child been seen on an emergency basis? ___ Yes ___ No

List: _____

Prior surgery? ___ Yes ___ No

List: _____

It is important that our patients and we have the same health objectives concerning chiropractic care. Regardless of what a disease or condition is called we do not offer to treat it. Our only practice objective is to eliminate a major interference to the expression of the body's internal wisdom. Our only method is specific adjusting to correct vertebral subluxations. We believe that the greatest Doctor is the one already inside each of our patients and we only help to maximize that inherent healing power, without using drugs or surgery. Your signature verifies that the information given in this form is complete and correct and that you accept for your child, if eligible, chiropractic care on this basis.

Parent / Guardian Signature

Date