Personal & Family Health History Date_____

Name_____ Referred by_____

Address_____City_____State_____Zip_____

Phone (H)_____(W)_____(C)_____

SS#_____E-Mail_____

Date of Birth_____ Age_____ Sex ____ M _____ F

Marital Status ___ S ___ M ___ D ___ W ___ Significant Other

Occupation_____ Employer_____

Spouse/Significant Other's Name_____

Spouse/Significant Other's Occupation _____Employer_____

Name of Children & Ages

1st_____ Age____ 4th _____ Age_____
2nd_____Age____ 5th _____ Age_____
3rd _____Age____ 6th _____ Age_____

Have YOU ever been to a chiropractor before? ___Y ___N Results_____

You deserve to be healthy and have a good Quality of Life. 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 distortion to your health expression, called the atlas subluxation complex. Through your examination and through your involvement in Upper-Cervical 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.

Birth Process (yours)
__ Long delivery __Difficult delivery __Forceps __Caesarian __Breach __Home Birth __Induced labor

Growth & Development
__Head Injuries __Spine Injuries __Child Abuse __Fallen Down the Stairs __ Ever Unconscious
__Any Broken Bones __Vaccines Other_____

Current Health Habits
__ Smoke __Poor diet __Use recreational drugs __Use artificial sweeteners __Drink alcohol
__Take yearly flu shots __No exercise program __Have family stress __Have mental stress
__Have occupational stress Other_____

Current Health Condition

Reason for today's visit_____

How long have you had this symptom? __Days __Weeks __Months __Years

What activities aggravate your condition? __Standing __Walking __Sitting __Bending __Twisting
Other_____

Is condition worse at different times of the day? __AM __PM __Sleeping

Condition interfering with work __Y __N Sleep __Y __N Daily Routine __Y __N

Condition progressively getting worse? __Y __N __Same

Other doctors seen for this problem? __Y __N Who?_____

Any falls, accidents or sports injuries?_____

_____

How many Car/Motorcycle Accidents even if they were minor? Write the year of the accident(s) in the blank.

_____Read end _____Broadside _____Head on _____Thrown out _____Rolled

Check Other Symptoms in the last 6 months or since accident.

__Acid Reflux	__Diarrhea	__High/Low blood pressure	__Neck stiff
__Allergies	__Dizziness	__Irritability	__Numbness in toes/fingers
__Balance	__Ears ring R L	__Knee pain R L	__Panic Attacks
__Bowel problems	__Fainting	__Light bothers eyes	__Pins & Needles in arms/legs
__Carpal Tunnel	__Fatigue	__Loss of memory	__Shortness of breath
__Chest pains	__Feet/Hand pain	__Low Back pain	__Sinus problems
__Cold sweats	__Fevers	__Menstrual Cramps	__Sleeping problems
__Constipation	__Gas	__Stomach upset	__Depression
__Headaches	__Neck pain	__Tightness between shoulders	

Additional Symptoms:_____

Pregnant __Y __N

Explain any surgeries within past year: _____

_____

List Medications taken for what Symptoms:_____

_____

If you could get rid of one symptom today, maybe the symptom that brought you into our office or another symptom; to eliminate that symptom out of your life forever, the one symptom that AFFECTS your lifestyle the most, WHAT WOULD IT BE?

_____

How long have you had this symptom? __Days __Weeks __Months __Years

When this symptom is at its absolute worst, how does it make you feel?

_____

_____

If you could get rid of this symptom, what would your commitment be from 1 through 10. (10 being the highest commitment, 1 being the lowest commitment) Circle 1 2 3 4 5 6 7 8 9 10

As a result of my Upper-Cervical Chiropractic care in this office, I would like to achieve: (Please check all that apply)

__ Symptom Relief __More Energy __Become More Active __Healthier Spine

__Healthier Body __Healthier Lifestyle __Better Quality of Life

What type of care do you want?

___Relief Care that is necessary to reduce or eliminate your symptoms or pain, but not the cause of it. It is the same as drying a floor that was getting wet from a leak, but not fixing the leak. This care is not recommended because the health problem is never handled, progressively getting worse over time.

___Corrective Care to correct the problem by addressing the cause of why your body may not be healing, adapting or repairing that which is controlled by your nerve system. Corrective care varies in length of time, but is more lasting and improves the overall health of a person. Corrective and stabilization care goals are to enhance your Quality of Life. This care is recommended by Yardley Chiropractic.

___ Not Sure what type of care I want.

I understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment and should I desire credit to be extended, I authorize any necessary credit verification. I also understand that if I suspend or terminate my care fees for professional services rendered will be immediately due and payable. I have been advised and concur, past due accounts will bear interest at 1% per month on the past due balance. I am responsible for costs required to enforce collection of my account including, but not limited to, collection fees, attorney fees and court costs. There is a $35.00 charge for returned checks.

_____ Date_____

Practice Member's Signature or Guardian

Do Not Write Below This Line Do Not Write Below This line

X-Rays __Y __N Consult Only __

Comments _____