CONTINUUM CHIROPRACTIC ADULT HEALTH HISTORY FORM

Today's Date________________________

PERSONAL DATA

Legal Name ____Preferred Name________________________

Age ____________ Date of Birth __________________ Height _______________________ Weight ________________

Home Address _____________________________________ City ___________________ State ______ Zip ____________

Home phone (____) _____________________________ Business Phone (____) _________________________________

Cell Phone (____) ________________________ SS#______________________________

E-mail address____

Occupation _______________________________ Employer ____

Marital Status ❑ S ❑ M ❑ D ❑ W Spouse/Partner ____

Names and Ages of Children____

How did you hear about our office? ____

REASON FOR SEEKING CHIROPRACTIC CARE

What concerns do you feel Continuum Chiropractic can address for you? _______________________________________

____

Are these concerns affecting your quality of life? (Please circle all that apply)

Work:	Y	N	Driving:	Y	N	Sleep:	Y	N
School:	Y	N	Walking:	Y	N	Sitting:	Y	N
Exercise/sports:	Y	N	Eating:	Y	N	Love life:	Y	N

HEALTH CARE PRACTITIONER HISTORY

Have you ever received Chiropractic care? ❑Y ❑ N Name of D.C. ________________________________

How long under care? ❑ ______days ❑______weeks ❑______months ❑______ years

Date of last visit: ____________________Why did you stop care?____

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

❑ Medical Physician ❑ Naturopath ❑ Acupuncturist ❑ Homeopath

❑ Massage Therapist ❑ Psychotherapist ❑ Dentist ❑ Physical or Occupational Therapist

Reason:____

____

FOR WOMAN

Are you pregnant? Y N Date of last menstrual period: ______________________________________

If x-rays are recommended, your signature is required (below) to verify that you are **not pregnant**.

Signature: ____Date:_________________________________

If **pregnant**, Due Date: _____________ Name of OBGYN or Midwife_____________________________________

Where will you be birthing your baby? ❑ Hospital ❑ Home ❑ Birthing Center ❑ Other_____________________

Is this your first pregnancy? Y N Number of other pregnancies: ____________

Have you had any complications with this, or any other, pregnancy? Y N
Details:____

____

CHILDHOOD THROUGH ADULT

The minor & often ignored repetitive physical traumas that we have endured are often too numerous to list.
Please list the major traumas that you remember from your childhood up to the present. _________________________

____

____

Have you had any accidents due to any of the following? (Check all that apply)

❑ Automobile ❑ Motorcycle ❑ Bicycle ❑ Sports ❑ Playground ❑ Abuse

If yes, state type of injury and date:

____

Have you ever fractured or severely injured any bones or joints (spine, head, neck, ribs, chest, upper or lower back, pelvis or hips, legs or arms)? ❑ Y ❑ N

If yes, list body parts injured and dates of injuries:

____

____

Have you ever been hospitalized or had surgery? ❑ Y ❑ N

If yes, state reason and dates: ____

Do you have allergies or sensitivities to food or other substances? ❑ Y ❑ N If yes, please list:

____

Do you <u>presently</u> consume any of the following?

❑ Coffee/caffeine ❑ Alcohol ❑ Tobacco ❑ Over the counter drugs ❑ Prescribed drugs
❑ Recreational drugs

Please list all medications (prescribed <u>and</u> over the counter):____

____

____

Note: It is imperative that you list all medications as they may have an influence on your care.

QUALITY OF LIFE (presently)

How do you grade your physical health? ❑ Good ❑ Fair ❑ Poor

How do you grade your emotional/mental health? ❑ Good ❑ Fair ❑ Poor

How do you rate your overall "quality of life"? ❑ Good ❑ Fair ❑ Poor

Do you exercise regularly? If yes, how often? ______________________________

Do you take supplements? If yes, please list: ______________________________

Do you follow a special dietary regime? ______________________________

In what position do you sleep at night? ❑ Back ❑ Stomach ❑ Side

How many hours of sleep do you get per night? _________ Quality? ❑ Good ❑ Fair ❑Poor

YOUR HEALTH HISTORY

Indicate C for current and P for past

____ Weight changes	____ Arm/hand pain	____ HIV or AIDS
____ Frequent infections	____ Leg/foot pain	____ High blood pressure
____ Respiratory disease	____ Memory issues	____ Low blood pressure
____ Sinus problems	____ Thyroid disorder	____ Headaches
____ Heart Disease	____ Difficulty sleeping	____ Fatigue
____ Joint pain	____ Difficulty breathing	____ Stress difficulty
____ Allergies	____ High cholesterol	____ Diabetes
____ Asthma	____ Stroke	____ Arthritis
____ Numbness/Tingling	____ Nervous disorder	____ Jaw/TMJ issues
____ Cold hands/feet	____ Digestive problems	____ Bowel/bladder habit changes
____ Neck pain	____ Cancer	____ Concussion /Head injury
____ Back pain	____ Menstrual problems/ pain	____ Neurological issue

Details:____

____

____

FAMILY HEALTH HISTORY

Has any member of your family (parents, grandparents, or siblings) ever had any of the following conditions?

❑ Cancer ❑ Heart disease ❑ Stroke ❑ Diabetes ❑ Progressive neurological disease

❑ Progressive neurological disease ❑ High blood pressure ❑ Other

Details:____

____

____

YOUR EXPECTATIONS FROM CHIROPRACTIC CARE

I would like to experience the following benefits from Chiropractic Care: (Check all that apply)

- ❒ Relief of a symptom or problem
- ❒ Relief and Prevention of a symptom or problem
- ❒ Healthier spine and nerve system
- ❒ Optimal health on all levels
- ❒ OTHER____

Important: Is there anything else that you would like our doctors to know? ______________________________

____

____

____

Describe aspects of your health that you feel are positive: ____

____

____

____

____

INFORMATION ABOUT FINANCES

Payment in full is expected on all FIRST VISIT services (whether you have insurance coverage or not.) All other fees are to be paid at time of service until other arrangements have been made and agreed upon in writing.

Please indicate your method of payment. ❑ Cash ❑ Check ❑ Credit Card

INSURANCE INFORMATION

Insurance coverage varies greatly. We do not look up or file insurance in this office, but will gladly print any necessary information if you choose to file on your own.

PLEASE READ AND SIGN

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

Name: (Printed) ____Date: ________________________

Signature:____

Signature of Parent (for minor):_________________________________ Date: ________________________

Thank you for choosing Continuum Chiropractic.
We look forward to helping you.