

Hedlund Chiropractic, P.A.

“Everybody’s Chiropractor!”

Personal and Family Health History

Name _____
 Date _____
 Address _____
 City _____ State _____ Zip _____
 Phone: (Home) _____
 (Work) _____ (Cell) _____
 E-mail _____
 Date of Birth _____ (Age _____)

Who may we thank for referring? _____
 Social Security # _____
 Occupation _____
 Employer _____
 Marital Status: Single - Married - Divorced - Widowed
 Spouse’s Name _____
 Spouse’s Occupation _____

Number of Children and Ages

Name _____ Age _____
 Name _____ Age _____
 Name _____ Age _____
 Name _____ Age _____

Previous Chiropractic Care?

Yes No Reason _____
 Yes No Reason _____
 Yes No Reason _____
 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 blue-prints, 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.

<u>Was Your Birth Traumatic?</u>	<u>Patient</u>	<u>Spouse</u>	<u>Child#1</u>	<u>Child#2</u>	<u>Child #3</u>	<u>Chiropractor’s Comments</u>
Difficult Delivery?	Y	Y	Y	Y	Y	_____
Forceps?	Y	Y	Y	Y	Y	_____
Caesarian?	Y	Y	Y	Y	Y	_____
Home birth?	Y	Y	Y	Y	Y	_____
<u>Growth and Development</u>						
<u>Did you ever once...</u>						
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	_____
Fall off a bike?	Y	Y	Y	Y	Y	_____
Have any Accidents?	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	_____
Spanking?	Y	Y	Y	Y	Y	_____
Pulled Ear / Chin?	Y	Y	Y	Y	Y	_____
Chair pulled out when sitting?	Y	Y	Y	Y	Y	_____
Fall down the stairs?	Y	Y	Y	Y	Y	_____
Experience other traumas?	Y	Y	Y	Y	Y	_____
<u>Current Health Habits</u>						
<u>Did / do you...</u>						
Smoke?	Y	Y	Y	Y	Y	_____
Drink Alcohol?	Y	Y	Y	Y	Y	_____
Do you eat healthy foods?	Y	Y	Y	Y	Y	_____
Have you been in accidents?	Y	Y	Y	Y	Y	_____
Have you had surgery or organs replaced/removed?	Y	Y	Y	Y	Y	_____
Drugs? (Prescriptive or Non-Prescriptive)	Y	Y	Y	Y	Y	_____
Exercise regularly?	Y	Y	Y	Y	Y	_____
Have sleeping problems?	Y	Y	Y	Y	Y	_____
Have occupational stress?	Y	Y	Y	Y	Y	_____
Have physical stress?	Y	Y	Y	Y	Y	_____
Have mental stress?	Y	Y	Y	Y	Y	_____
Have hobbies/sports injuries?	Y	Y	Y	Y	Y	_____
Sleeping posture – side–stomach–back	_____	_____	_____	_____	_____	_____

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Current Health Condition

Reason For Your Visit Today? _____ R: _____

When did the Pain or Problem start? _____ S: _____

Pains are: Sharp Dull Constant Intermittent (off and on) T: _____

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? _____

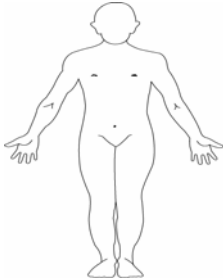
Other Doctors seen for this condition _____

Any home remedies? _____

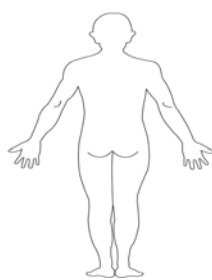
Other symptoms:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Numbness – Arm / Hand | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Stiff Joints |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Thyroid Condition | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Loss of Feeling |
| <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Tired / Fatigue | <input type="checkbox"/> Constipation | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Shoulder Problems | <input type="checkbox"/> Menstrual Cramps | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> Problems between Shoulders | <input type="checkbox"/> Low Back Problems | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Mid Back Problems | <input type="checkbox"/> Legs Problems | <input type="checkbox"/> ADD / ADHD |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Asthma | <input type="checkbox"/> Numbness – Leg / Foot | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Chest Pain / Discomfort | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Tension |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Heart Burn / Indigestion | <input type="checkbox"/> Weak Muscles | <input type="checkbox"/> Blood Clots |
| <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Muscle Cramps | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Loss of Taste | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Sore Muscles | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Neck Problems | <input type="checkbox"/> Nausea | <input type="checkbox"/> Walking Problems | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Stiff Neck | <input type="checkbox"/> Poor Digestion | <input type="checkbox"/> Restricted Regular Exercise | <input type="checkbox"/> Broken Bones |
| <input type="checkbox"/> Arm Problems | <input type="checkbox"/> Stomach Upset | <input type="checkbox"/> Restricted Daily Activity | <input type="checkbox"/> Dislocation |

Front



Back



← Label the areas of complaints on your body

Numberness	Pins & Needles	Burning	Aching	Stabbing
N	P	B	A	S

Have you been under drug and medical care for your current condition? _____

What medications are you taking for your current symptom? _____ How Long? _____

Have you had surgery? Yes No What? _____ When? _____

Any side effects you’ve experienced from the drugs or 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 Report 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, I would like to:

Please check all that apply:

- | | |
|---|---|
| <input type="checkbox"/> Feel better quickly | <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)