



Dr. Lisa S. Olszewski  
 Upper Cervical Chiropractor

**Personal and Family Health History**

Name \_\_\_\_\_

Date: \_\_\_\_\_

Sex: Male \_\_\_\_\_ Female \_\_\_\_\_ Date of Birth \_\_\_\_\_

Occupation \_\_\_\_\_

Address \_\_\_\_\_

Employer \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employed Full time( ) Part time ( )

Phone: (H) \_\_\_\_\_ (W) \_\_\_\_\_

Retired ( ) Date of Retirement \_\_\_\_\_

(Cell) \_\_\_\_\_

Marital Status S M D W

If needed to be contacted during day time

Spouse's Name \_\_\_\_\_

hours use this number \_\_\_\_\_

Spouse's Occupation \_\_\_\_\_

In case of an emergency contact: \_\_\_\_\_

Referred By \_\_\_\_\_

Emergency contact number \_\_\_\_\_

Previous Chiropractic Care? \_\_\_\_\_

Approx number of adjustments over your lifetime \_\_\_\_\_

**Number of Children and Ages**

**Previous Chiropractic Care?**

Name \_\_\_\_\_ Age \_\_\_\_\_ 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.

	<b>Patient</b>	<b>Spouse</b>	<b>Child#1</b>	<b>Child#2</b>	<b>Child #3</b>	<b>Chiropractor's Comments</b>
<b>Circle all that Apply</b>						
<b>1. Was Your Birth Traumatic?</b>						
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	_____
<b>2. Growth and Development</b>						
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	_____
Have Ear Infections	Y	Y	Y	Y	Y	_____
Take medication?	Y	Y	Y	Y	Y	_____
Fall while learning to walk?	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 or use other tobacco products?	Y	Y	Y	Y	Y	_____
Drink?	Y	Y	Y	Y	Y	_____
Diet (do you eat healthy foods?)	Y	Y	Y	Y	Y	_____
Have you been in accidents?	Y	Y	Y	Y	Y	_____
Have you had surgery and organs replaced/removed?	Y	Y	Y	Y	Y	_____
Drugs? (Prescriptive or Non-Prescriptive)	Y	Y	Y	Y	Y	_____
Have Teeth Problems?	Y	Y	Y	Y	Y	_____
Have Eye Problems?	Y	Y	Y	Y	Y	_____
Have Hearing Problems?	Y	Y	Y	Y	Y	_____
Exercise regularly?	Y	Y	Y	Y	Y	_____
Have sleeping problems? (nightmares)?	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	_____	_____	_____	_____	_____	_____

**Current Health Condition**

Present Complaint (be brief) Reason For Your Visit Today

Major \_\_\_\_\_

How long have you been living this way? \_\_\_\_\_

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? \_\_\_\_\_ Family Life? \_\_\_\_\_ Social Life? \_\_\_\_\_

Ability to Exercise? \_\_\_\_\_ Hobbies? \_\_\_\_\_ 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"/> Dizziness              | <input type="checkbox"/> Depression         | <input type="checkbox"/> Diarrhea        |
| <input type="checkbox"/> Neck Pain         | <input type="checkbox"/> Face Flushed           | <input type="checkbox"/> Light Bothers Eyes | <input type="checkbox"/> Feet Cold       |
| <input type="checkbox"/> Blurred Vision    | <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"/> Frequent Colds  |
| <input type="checkbox"/> Irritability      | <input type="checkbox"/> Shortness of Breath    | <input type="checkbox"/> Loss of Smell      | <input type="checkbox"/> Loss of Energy  |
| <input type="checkbox"/> Chest Pains       | <input type="checkbox"/> Fatigue                | <input type="checkbox"/> Loss of Taste      |  |

Are you under medical care? \_\_\_\_\_

Doctor's Name: \_\_\_\_\_ Location: \_\_\_\_\_

What medications are you taking and for how long; \_\_\_\_\_

Have you had surgery? \_\_\_\_\_ 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"/>

What are your objectives from receiving and maintaining your spinal correction at Precision Spinal Care?

Are you willing to be an active participant in the improvement of your health? \_\_\_\_\_

Name and address of the last health professional that put you on a wellness program: \_\_\_\_\_

*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

“The doctor of the future will give no medicine but will interest his patients in the care of the human frame, in diet, and in the cause and prevention of disease.”

Thomas A. Edison