Mountain Community Wellness Center

PERSONAL HISTORY QUESTIONNAIRE

(please print)

Today's Date: ____/____/____ Email address:_____

Patient's Full Name:_____ M ☐ F ☐ Age:_____ Date of Birth:_____/_____/_____

Address:_____
street address city state zipcode

Home Phone ( )_____ Work ( )_____Cell ( )_____

Relationship Status: Single ☐ Partnered ☐ Married ☐ Divorced ☐ Widowed ☐ # Children:_____

Name of Partner, Spouse or Guardian:_____ Occupation:_____

Height:_____ Weight:_____ Pregnant? Y N Work Schedule_____

Who may we thank for referring you to our office?_____

INSURANCE INFORMATION:

Insurance Provider:_____ Policy#:_____ Group#:_____

Name of Primary Policy Holder:_____ Date of Birth:_____/_____/_____
if different from patient

CHIROPRACTIC HISTORY:

Previous Chiropractor(s):_____ Last Visit?_____

How long under Chiropractic care?_____ How often did you go?_____

If you stopped, why?_____

Were you pleased with his or her service? Y☐ N☐ Does your immediate family receive chiropractic care? Y☐ N☐

What do you hope to receive from Chiropractic Care in our office?_____
If additional space is needed for descriptions, please continue on last page of this form

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PHYSICAL HISTORY:

Was your birth: Drug Induced☐ C Section☐ Breech☐ Forceps☐ Suction☐ Cord around neck☐ Prolonged☐ Traumatic☐

Describe: _____

Have you ever had a head injury or concussion? Y ☐ N ☐ Date(s) & Describe: _____

_____

Have you ever had any falls, jolts or impacts to your spine? Y☐ N☐ Date(s) & Describe ALL: _____

_____

_____

If additional space is needed for descriptions, please continue on last page of this form

VEHICULAR ACCIDENTS:

1. Accident Date or Age:_____ Auto ☐ Motorcycle ☐ Bicycle ☐ Other_____

Driver? ☐ Passenger? ☐ How was vehicle hit? _____

Were you injured? Y☐ N☐ Describe: _____

If additional space is needed for descriptions, please continue on last page of this form

2. Accident Date or Age: _____ Auto ☐ Motorcycle ☐ Bicycle ☐ Other_____

Driver? ☐ Passenger? ☐ How was vehicle hit? _____

3. Accident Date or Age: _____ Auto ☐ Motorcycle ☐ Bicycle ☐ Other_____

Driver? ☐ Passenger? ☐ How was vehicle hit? _____

Were you injured? Y☐ N☐ Describe: _____

If additional space is needed for descriptions, please continue on last page of this form

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MEDICAL TREATMENT: Please list ALL surgeries and hospital stays:

1. Date or age:_____ Describe:_____

2. Date or Age:_____Describe:_____

3. Date or Age:_____Describe:_____

If additional space is needed for descriptions, please continue on last page of this form

Have you had: Neck Collar☐ Traction☐ Physical Therapy☐ X-rays☐ Spinal Tap☐ Radiotherapy☐
Chemotherapy ☐ Blood Transfusion ☐

Do you wear: Orthotics ☐ Heel Lifts ☐

EXERCISE & RECREATIONAL ACTIVITIES

Please list all activities and exercise: 1._____ Daily ☐ Weekly ☐ Monthly ☐ Past ☐

2._____ Daily ☐ Weekly ☐ Monthly ☐ Past ☐

Hobbies_____

CHEMICAL HISTORY Please list ALL prescription and non-prescription medications (including herbs) you are currently taking or have previously taken:
Describe what they are for:

1._____ Reason?_____ Prescribed? Y☐ N☐

2._____ Reason?_____ Prescribed? Y☐ N☐

3._____ Reason?_____ Prescribed? Y☐ N☐

4._____ Reason?_____ Prescribed? Y☐ N☐

Do you or did you work with Chemicals, fumes, powder or smoke for prolonged periods? Y☐ N☐ Explain:_____

_____

If additional space is needed for descriptions, please continue on last page of this form

CHEMICAL HISTORY: *(continued)* How often do you consume the following?

Alcohol:	Daily ☐	Weekly ☐	Monthly ☐	Past ☐
Coffee with caffeine:	Daily ☐	Weekly ☐	Monthly ☐	Past ☐
Tea with caffeine:	Daily ☐	Weekly ☐	Monthly ☐	Past ☐
Soda:	Daily ☐	Weekly ☐	Monthly ☐	Past ☐
Artificial Sweeteners:	Daily ☐	Weekly ☐	Monthly ☐	Past ☐
Tobacco:	Daily ☐	Weekly ☐	Monthly ☐	Past ☐
Water:	Daily ☐	Weekly ☐	Monthly ☐	Past ☐
Bowel Movement:	Daily ☐	Weekly ☐	Monthly ☐	Past ☐

EMOTIONAL HISTORY: Please grade the following stressful situations if they apply:

	CURRENTLY		IN THE PAST	
School Stress	Moderate ☐	Extreme ☐	Moderate ☐	Extreme ☐
Family stress	Moderate ☐	Extreme ☐	Moderate ☐	Extreme ☐
Work stress	Moderate ☐	Extreme ☐	Moderate ☐	Extreme ☐
Personal relationships	Moderate ☐	Extreme ☐	Moderate ☐	Extreme ☐
Stress of being sick	Moderate ☐	Extreme ☐	Moderate ☐	Extreme ☐
Change in lifestyle	Moderate ☐	Extreme ☐	Moderate ☐	Extreme ☐
Change in vocation	Moderate ☐	Extreme ☐	Moderate ☐	Extreme ☐
Loss of a loved one	Moderate ☐	Extreme ☐	Moderate ☐	Extreme ☐
Abuse (physical / emotional)	Moderate ☐	Extreme ☐	Moderate ☐	Extreme ☐

PRIMARY COMPLAINT: _____

Date Symptom first appeared:_____ Did it begin: ☐ Gradual ☐ Sudden ☐ Progessive over time

What makes the symptoms increase?_____ What relieves the symptoms?_____

Type of Pain: ☐ Sharp ☐ Dull ☐ Ache ☐ Burn ☐ Throb Does the Pain Radiate into: ☐ Arm ☐ Leg ☐ Does not radiate

Do you have Numbness or Tingling? ☐ Yes ☐ No How often do you experience these symptoms? ☐ 100% ☐ 50% ☐ 25% ☐ 10%

Please rate the intensity of your symptoms on a scale of 1-10 (1=none, 10=extreme)_____

Please list all previous treatments for this condition (give doctor's name/dates if possible:_____

_____

SECONDARY COMPLAINT: _____

Date Symptom first appeared:_____ Did it begin: ☐ Gradual ☐ Sudden ☐ Progressive over time

What makes the symptoms increase?_____ What relieves the symptoms?_____

Type of Pain: ☐ Sharp ☐ Dull ☐ Ache ☐ Burn ☐ Throb Does the Pain Radiate into: ☐ Arm ☐ Leg ☐ Does not radiate

Do you have Numbness or Tingling? ☐ Yes ☐ No How often do you experience these symptoms? ☐ 100% ☐ 50% ☐ 25% ☐ 10%

Please rate the intensity of your symptoms on a scale of 1-10 (1=none, 10=extreme)_____

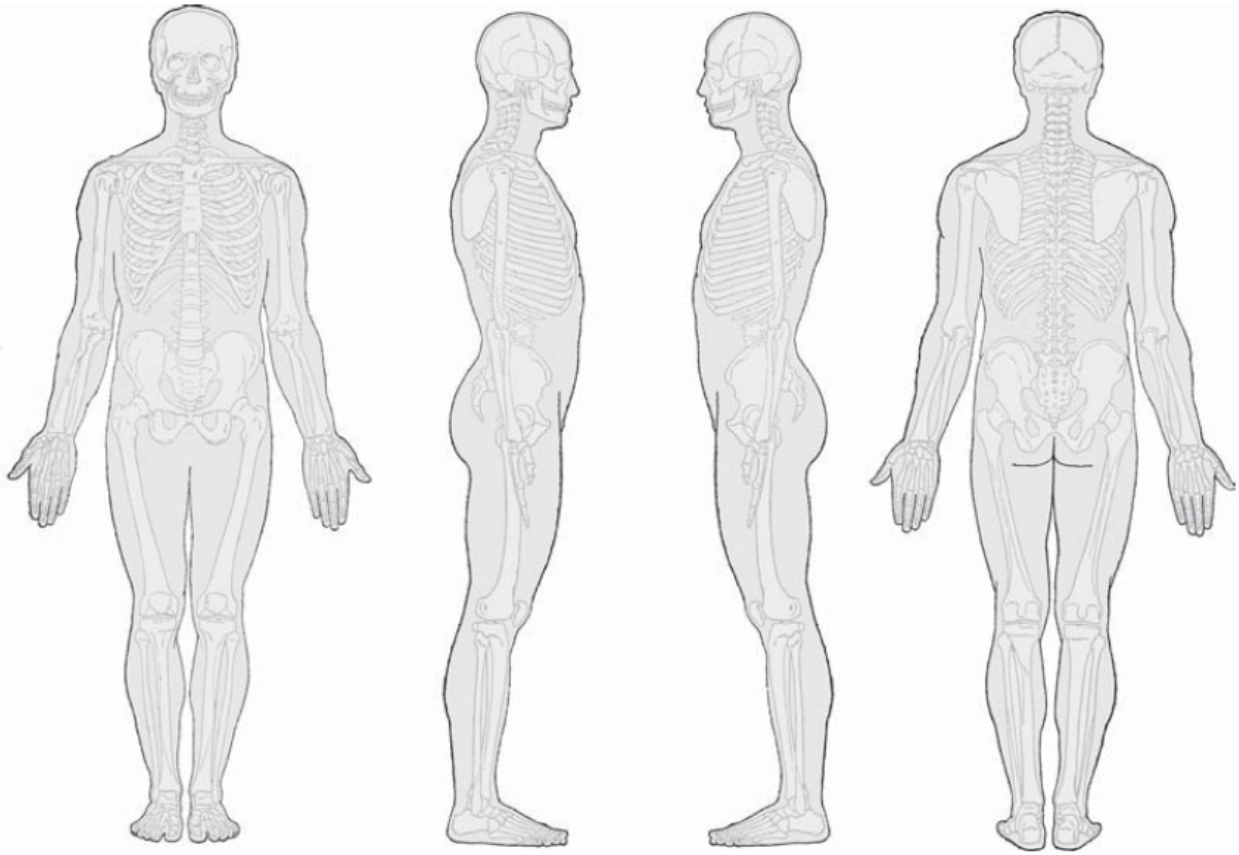
Please list all previous treatments for this condition (give doctor's name/dates if possible:_____

_____

Additional Symptoms/Complaints:

Please mark the areas of your complaint on the picture(s) above with the following indicators:

P = pain
N = numbness
T = tingling
B = burning
C = cramping
S = spasm
X = other



Please check if you have had any of the following:

☐ Addictions	☐ Cancer	☐ Heart Attack	☐ Mononucleosis	☐ Thyroid Problems
☐ AIDS/HIV	☐ Cataracts	☐ Heart Disease	☐ MS	☐ Tonsillitis
☐ Alcoholism	☐ Chemical Dependency	☐ Hepatitis	☐ Mumps	☐ Tuberculosis
☐ Anemia	☐ Chicken Pox	☐ Hernia	☐ Osteoporosis	☐ Tumors/Growths
☐ Allergy Shots	☐ Diabetes	☐ Herpes	☐ Pacemaker	☐ Typhoid Fever
☐ Anorexia	☐ Disc Degeneration	☐ High Blood Pressure	☐ Parkinson's Disease	☐ Ulcers
☐ Arthritis	☐ Emphysema	☐ High Cholesterol	☐ Pinched Nerve	☐ Vascular Disease
☐ Asthma	☐ Epilepsy	☐ Kidney Disease	☐ Pneumonia	☐ Vaginal Infections
☐ Bleeding Disorders	☐ Glaucoma	☐ Liver Disease	☐ Polio	☐ Venereal Disease
☐ Breast Lump	☐ Goiter	☐ Measles	☐ Prostate Problem	☐ Whooping Cough
☐ Bronchitis	☐ Gonorrhea	☐ Migraine	☐ Prosthesis	☐ Rheumatoid Arthritis
☐ Bulimia	☐ Gout	☐ Miscarriage	☐ Psychiatric Care	☐ Other:

FAMILY HEALTH HISTORY: (Mother, Father, Siblings, Grandparents)
Associated health problems of relatives:_____

_____

_____

Deaths in immediate family: Cause of parents or siblings death Age at death

_____ _____

_____ _____

_____ _____

If additional space is needed for descriptions, please continue on last page of this form

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I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes.

Patient Signature_____

Date:_____

Parent or Guardian Signature_____

Date:_____

PHYSICAL HISTORY (continued)

VEHICULAR ACCIDENTS (continued)

MEDICAL TREATMENT (continued)

CHEMICAL HISTORY (continued)

FAMILY HISTORY (continued)

ADDITIONAL HEALTH CONCERNS (continued)