

Old Orchard Beach Chiropractic

Personal and Family Health History

Name _____
 Date _____
 Address _____
 City _____ State ____ Zip _____
 Phone: (H) _____ (W) _____
 E-mail _____
 Date of Birth _____ (Age _____)

Referred By _____
 Social Security # _____
 Occupation _____
 Employer _____
 Marital Status S M D W
 Spouse's Name _____
 Spouse's Occupation _____

Number of Children and Ages

Name _____	Age _____	Yes ___	No ___	Reason _____
Name _____	Age _____	Yes ___	No ___	Reason _____
Name _____	Age _____	Yes ___	No ___	Reason _____
Name _____	Age _____	Yes ___	No ___	Reason _____

Previous Chiropractic Care?

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.

	Patient	Comments
Circle all that Apply		
1. Was Your Birth Traumatic?		
Long Delivery?	Y	_____
Difficult Delivery?	Y	_____
Forceps?	Y	_____
Caesarian?	Y	_____
Breach/cephalic?	Y	_____
Home birth?	Y	_____
Mother given drugs during delivery	Y	_____
Induced Labor?	Y	_____
2. Growth and Development		
Did you ever once...		
Learn to care for your spine?	Y	_____
Fall out of bed?	Y	_____
Bang your head?	Y	_____
Breastfeed?	Y	_____
Childhood sickness?	Y	_____
Have any Accidents?	Y	_____
Have Surgery?	Y	_____
Take Drugs?	Y	_____
Fall while learning to walk?	Y	_____
Bullied by your siblings?	Y	_____
Child abuse	Y	_____
Spanking?	Y	_____
Pulled ear/chin	Y	_____
Other	Y	_____
Chair pulled out when sitting?	Y	_____
Fall down the stairs?	Y	_____
Pulled by your arm?	Y	_____
Experience other traumas?	Y	_____
3. Current Health Habits		
Did/do you...		
Smoke?	Y	_____
Drink	Y	_____
Diet (do you eat healthy foods?)	Y	_____
Have you been in accidents?	Y	_____
Have you had surgery	Y	_____
and organs replaced/removed?	Y	_____
Drugs? (Prescriptive or Non-Prescriptive)	Y	_____
Have Teeth Problems?	Y	_____

