PERSONAL RECORD

NAME: _____ Today's Date: _____

ADDRESS: _____ Birth Date: _____ Age: _____

_____ Best Phone: _____

(City, State, Zip) Work Phone: _____

E-mail address: _____ Occupation: _____

Emergency Contact: _____ Referred by: _____

Emergency Contact Phone: _____

Pacemaker or other electronic implant? **Y N** If yes, device: _____

Main health concerns for this visit: (provide up to three if needed)

1) Concern: _____

Current symptoms: _____

Length of time had symptoms: _____

What makes symptoms better or worse: _____

2) Concern: _____

Current symptoms: _____

Length of time had symptoms: _____

What makes symptoms better or worse: _____

3) Concern: _____

Current symptoms: _____

Length of time had symptoms: _____

What makes symptoms better or worse: _____

Area on body where pain or concern is located:

Have you seen a doctor or other alternative health provider for this condition? **Y N** If yes, please provide information on who you saw and diagnosis.

Are you under doctor's care for any reason? **Y N** If so, please list/explain:

Are you currently receiving any other kinds of healing modalities? **Y N** If yes, please list:

Medications and/or Supplements currently taking: (include name, dosage, and length of time taking)

When you were born, was it a difficult birth? **Y N** Very rapid birth? **Y N** C-section? **Y N** Forceps? **Y N**
Comments:

Have you had any blows to the head? (need not have caused unconsciousness. Examples: Fall from a bicycle or down stairs, car or sports accident, object hitting head, etc.) **Y N** If yes, describe what happened and approximate date(s) and age(s); also describe any problems experienced afterward)

Have you ever experienced a "whiplash"? **Y N** (if yes, please say what happened and what you experienced afterward)

Have you ever had any fractures, sprains, or other sports or auto injuries? **Y N** If yes, provide type, approximate date(s) and age(s).

Have you had any surgeries? **Y N** If yes, please list and approximate date(s) and age(s).

Have you ever experienced chiropractic manipulation? **Y N** If yes, please list what it was for and area of body adjusted.

Exercise/Physical Activity pattern (walking/weights/aerobics/frequency):

Family Health History (parents/siblings/grandparents - describe major health issues):

Describe your diet. Check the one(s) that most aptly describes your eating pattern, and elaborate in the space provided.

- ●Heavy meat (all kinds)
- ●Some vegetarian (eat chicken or fish)
- ●Vegetarian (no meat)
- ●Vegan (no eggs or milk products)

_____ % red meat
_____ % chicken or fish
_____ % vegetables
_____ % fruits
_____ % grains
_____ % other (describe) _____
100%

Further description of your diet:

Do you use any of the following: (please indicate amounts and frequency)

●Alcohol ●Sugar
●Coffee ●Tobacco
●Recreational drugs

List any childhood diseases you have had (e.g. measles, mumps, chickenpox, scarlet fever, etc.)

Do you have any allergies? **Y N** If yes, please list type of allergy and also if it relates to airborne or environmental.

Do any other members of your family have any allergies? **Y N**

Do you have any respiratory/sinus problems? **Y N** Skin irritations? **Y N** Other? **Y N**
If yes, please describe:

Circle symptoms you have or have had in the last **60 days:**

Eyes, Ears, Nose, Throat
●Sinus problems ●Cough ●Sore throat ●Itchy eyes ●Red eyes
●Ringing in Ears ●Loss of hearing ●Vision problems ●Other: _____

Sleep
●No problems ●Trouble falling asleep ●Trouble staying asleep
●Trouble staying asleep as well as falling asleep ●Hours of sleep you get a night: _____
●Other: _____

Mood
●Anxiety ●Depression ●Brain Fog ●Fatigue/Tired ●Irritability ●Stress
●Other: _____

Cardiovascular
●Chest Pain ●Difficulty Breathing ●Fainting/Dizziness ●Heart Disease
●High Blood Pressure ●Irregular Heart Beat ●Palpitations/Heart Racing
●Other: _____

Gastro/Intestinal
●Constipation ●Diarrhea ●Difficulty swallowing ●Poor appetite ●Nausea
●Food Sensitivity ●Vomiting ●Heartburn/Acid Reflux
●Bowel movements: _____ (times/day); every _____ days
●Other: _____

Urinary
●Bladder infection ●Frequent Urination ●Kidney Stones ●Painful Urination
●Incontinence ●Other: _____

Muscles, Joints, and Bones
●Tremors ●Swollen Joints ●Pain in Joints ●Body Aches ●Cramps
●Heavy Feeling in Limbs ●Other: _____

Pain, Weakness and or Numbness

●Headache ●Hands, Arms, Shoulders ●Upper Back, Neck ●Face, Jaw ●Mid-Back
●Low Back ●Hip ●Knees ●Ankles, Feet, Heels
●Other: _____

For women only:

Number of pregnancies: _____ Number of children: _____
Type of contraception (if applicable): _____

Please indicate if you have any of the following:

●Premenstrual syndrome ●Menopausal ●Peri-menopausal
●Light or excessive menstrual flow ●Severe menstrual pain ●Irregular cycle
●Pregnant now? **Y N** ●Difficulty conceiving
●Lack of sex drive ●Other: _____

For men only:

●Vasectomy ●Prostate problems ●Erectile dysfunction
●Loss of sex drive ●Genital pain and/or swelling ●Frequent need to urinate
●Premature ejaculation ●Other: _____

Please list any other information that you feel may be helpful in your health assessment:

Thank you!

To the best of my knowledge, I have listed all of my past and current conditions.

_____ _____
Signature Date: