PERSONAL HISTORY QUESTIONNAIRE

Date: ___/___/___

Name: _____ Address: _____

City: _____ State: _____ Zip: _____ Occupation: _____

E-Mail: _____ Home Phone: _____ Business Phone: _____

Date of Birth: _____ Age: _____ ❒ M ❒ F Marital Status: _____ No. of Children: _____

Social Security Number:(optional) _____ Insurance: _____

How did you hear about our office? _____

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT YOUR PERSONAL HISTORY:

1. Have you ever had your spine or nervous system examined professionally? ❒Yes ❒No

2. Have you ever received Network Spinal Analysis care? ❒Yes ❒No Network Chiropractic care? ❒Yes ❒No

   If yes, when was your last visit? _____ For how long were you going? _____

   How often did you go? _____ If you stopped, why did you stop going? _____

3. Were you pleased with his or her service? ❒Yes ❒No

4. Does your immediate family receive Network Care? ❒Yes ❒No

5. Have you had, or do you receive the following vehicles towards healing or growth?
   If yes, please list when and any comments you wish to share:

   Chiropractic: ❒Yes ❒No _____

   Bodywork / massage: ❒Yes ❒No _____

   Osteopathy / cranial work: ❒Yes ❒No _____

   Homeopathy/Accupuncture: ❒Yes ❒No _____

   Meditation: ❒Yes ❒No _____

   Psychotherapy: ❒Yes ❒No _____

   Movement or exercise: ❒Yes ❒No _____

   Somato Respiratory Integration: ❒Yes ❒No _____

   Yoga: ❒Yes ❒No Prayer: ❒Yes ❒No Other: _____

   Rebirthing / breathwork: ❒Yes ❒No _____

6. Do you currently have any health concerns? ❒Yes ❒No Please describe: _____

   _____

7. What do you hope to gain from the care in this office? _____

   _____

The practice of chiropractic is based upon the location and adjustment of vertebral subluxations. Subluxations are caused by any stress your body can not properly perceive, adapt to or recover from. These stresses may be PHYSICAL, CHEMICAL, or EMOTIONAL in nature.

PHYSICAL HISTORY - BIRTH STRESS: If you have Information about your birth history:

1. Was your mother outwardly ill prior to her pregnancy with you? ❒Yes ❒No
2. Did your mother have a difficult pregnancy with you? ❒Yes ❒No
3. Did your mother have any falls, accidents or physical injuries during pregnancy? ❒Yes ❒No
4. Was your birth traumatic? ❒Yes ❒No
5. Was your birth: ❒drug induced ❒forceps or suction ❒"C" section ❒Cord around the neck ❒breech ❒prolonged ❒Natural ❒Other: _____

6. Describe any other physical or mechanical stress to your mother or you as labor progressed, delivery progressed, or as a newborn.

_____

GENERAL PHYSICAL TRAUMA:

7. Next to each potential vertebral subluxation cause is a check box. Please check the appropriate box - either 'P' for past or 'C' for current, and the correct level of trauma: Mild, Moderate, or Extreme.

	MILD		MODERATE		EXTREME			MILD		MODERATE		EXTREME	
	P	C	P	C	P	C		P	C	P	C	P	C
Falls from crib, carriage	❒	❒	❒	❒	❒	❒	Sports impacts	❒	❒	❒	❒	❒	❒
Falls down or up steps	❒	❒	❒	❒	❒	❒	Physical fight	❒	❒	❒	❒	❒	❒
Falls on ice	❒	❒	❒	❒	❒	❒	Armed services	❒	❒	❒	❒	❒	❒

Comments: _____

8. Were you ever knocked unconscious? ❒Yes ❒No

Comments: _____

9. Have you ever used crutches, a walker, or cane? ❒Yes ❒No

Comments: _____

10. Have you ever broken any bones? ❒Yes ❒No

Comments: _____

11. Have you ever had any impacts, falls, or jolts that you feel specifically may have injured your spine? ❒Yes ❒No

Comments: _____

12. Have you had extensive dental or orthodontial work performed? ❒Yes ❒No

Comments: _____

13. Have you served in the military? ❒Yes ❒No From_____ to_____ Were you involved in combat? ❒Yes ❒No

14. During the day I: ❒sit ❒stand ❒walk ❒do desk work ❒phone work ❒drive ❒do mechanical work ❒heavy lifting

15. I exercise: ❒daily ❒weekly ❒monthly Describe: _____

SPORTS or LEISURE:

16. Were you, or are you active in any particular sport(s)? ❒Yes ❒No

Which one(s)? _____

17. Have you been hurt in any of these activities? ❒Yes ❒No

Comments: _____

18 Do you read for prolonged periods? ❒Yes ❒No

19 Do you play a musical instrument? ❒Yes ❒No

20 Do you have a particular position for watching television? ❒Yes ❒No

Comments: _____

21 I wear: ❒Glasses ❒Bifocals ❒Contact lenses

AUTOMOBILE ACCIDENTS:

22 Have you, (even as a passenger, even if you do not think you were hurt), been involved in a vehicular collision, or near collision? Please list approximate dates and severity (Mild, Moderate or Extreme).

Automobile: _____

_____

Bus, bicycle, motorcycle, train, airplane, moped, or other vehicles: _____

_____

MEDICAL TREATMENT:

23 Have you ever been hospitalized? ❒ Yes ❒ No If yes, what was actually done to you? _____

24 Have you had surgery? _____

25 Do you still have all your body parts? _____

26 Have you had: ❒ a spinal tap ❒ spinal injections ❒ physiotherapy ❒ neck collar ❒ spinal brace ❒ traction ❒ heel lift ❒ x - ray treatments ❒ corrective shoes or bars on shoes ❒ extensive diagnostic x - rays ❒ acupuncture ❒ chemotherapy ❒ transfusion ❒ body part in a cast or immobilized?

CHEMICAL HISTORY - BIRTH STRESS:

1 Was your mother regularly taking any drug immediately prior to, or during her pregnancy with you? ❒ Alcohol ❒ Smoking

Other?: _____

2 Was her labor chemically induced or altered? ❒ Yes ❒ No

3 Was your mother: ❒ conscious ❒ semiconscious ❒ unconscious during your delivery? ❒ Under spinal anesthesia during delivery?

4 Any other chemical stress that your mother may have been subject to during pregnancy or labor?: _____

GENERAL CHEMICAL TRAUMA:

5 Are you now taking any drug (prescription or over-the-counter) regularly? Please list drugs, when prescribed and reasons for taking them: _____

_____

Are these drugs being prescribed by a physician? ❒Yes ❒No Last visit: _____

6 If you were previously taking any medication regularly? Please describe: _____

_____

7 Do you or did you work with any chemical, fume, dust, powder, smoke for prolonged periods? ❒Yes ❒No

8. Please grade any dietary selection that is appropriate for you using the following scale:

0 - Do not consume this
M - Consume this monthly
FM - Consume a few times per month (less than weekly)
FD - Consume this a few times per day
W - Consume this weekly
FW - Consume this a few times per week
D - Consume this daily

_____ Alcohol	_____ Eggs	_____ Beef
_____ Coffee	_____ Cooked, canned vegetables	_____ Poultry
_____ Tobacco	_____ Raw Vegetables	_____ Fish
_____ Artificial Sweeteners	_____ Fruit	_____ Seafood
_____ Soda	_____ Whole Grains	_____ Weight Control Diet
_____ Diet Food	_____ Dairy (milk products)	_____ Fasting
_____ Refined Sugar	_____ Fried Foods	_____ Organic Foods

The type of diet I usually follow is classified as: _____

EMOTIONAL HISTORY - BIRTH STRESS:

1. My birth was: ❒at home ❒in a birthing center ❒ in a hospital ❒ other

2. Were you incubated or isolated after birth? ❒Yes ❒ No

3. Were you ❒bottle fed formula ❒ bottle fed mother's milk ❒ nursed ❒ nursed and bottle fed?

GENERAL EMOTIONAL TRAUMA:

4. With each of the following potential spinal stress situations, please check either "P" for past or "C" for current.

	MILD		MODERATE		EXTREME			MILD		MODERATE		EXTREME	
	P	C	P	C	P	C		P	C	P	C	P	C
Childhood stress	❒	❒	❒	❒	❒	❒	Work related stress	❒	❒	❒	❒	❒	❒
School stress	❒	❒	❒	❒	❒	❒	Stress of commuting	❒	❒	❒	❒	❒	❒
Play, or recreational	❒	❒	❒	❒	❒	❒	Loss of loved one	❒	❒	❒	❒	❒	❒
Family stress	❒	❒	❒	❒	❒	❒	Change in lifestyle	❒	❒	❒	❒	❒	❒
Personal relationships	❒	❒	❒	❒	❒	❒	Change in vocation	❒	❒	❒	❒	❒	❒
Stress of being sick	❒	❒	❒	❒	❒	❒	Abuse	❒	❒	❒	❒	❒	❒

5. How do you grade your physical health? ❒Excellent ❒Good ❒Fair ❒Poor ❒Getting Better ❒Getting Worse

6. How do you grade your emotional/mental health? ❒Excellent ❒Good ❒Fair ❒Poor ❒Getting Better ❒Getting Worse

7. If you consider yourself ill, why do you feel you are ill? _____

_____

8. If you consider yourself well, why do you feel you are well? _____

_____

9. Is there anything else you may wish to share which may help us to better understand you, and why you have chosen to see the doctor in this office? _____

_____

_____