

Chiropractic

1. Please enter your information.

First Name:	Middle Initials:	Last Name:	Date of Birth:	
_____	_____	_____	_____	
Street Address:	Apt./Unit #:	City:	State:	Zip Code:
_____	_____	_____	_____	_____
Home Phone:	Work Phone:	Age:		
_____	_____	_____		
Occupation:	Email:			
_____	_____			
Would you like to receive our e-mail newsletter?	Who referred you to this office?			
_____	_____			

Please complete this general health history survey, as it will provide your practitioner with important information to better understand your history, your present and longer term needs, and any compromises to your wellness or health related quality of life that you may now be experiencing

2. Part 1: Your Health Concern or Symptoms and How They May Effect Your Life

Do you have a current health concern? If so, please describe:

When did this situation or concern begin?

Have you taken any action regarding this concern or gotten any advice or treatment for it? If Yes, what were you told?

What was done?	Did it seem to work?
_____	_____

What was different about you after treatment?

What was different about your condition after treatment?

3. Please grade the level to which this health concern(s) affects these aspects of your functioning/quality of life. 0-Does not seem to affect me 1- Seems to slightly affect me 2- Seems to moderately affect me 3- Seems to drastically affect me

	0	1	2	3
Effect on work	0	1	2	3
Effect on social life	0	1	2	3
Effect on exercise	0	1	2	3
Effect on recreation/play	0	1	2	3
Effect on walking	0	1	2	3
Effect on eating	0	1	2	3
Concern about particular symptom/concern	0	1	2	3
Effect on sleep	0	1	2	3
Effect on sitting	0	1	2	3
Effect on love life	0	1	2	3
Concern about health	0	1	2	3

4. Please write down your definition of health:

5. Part 2: Health/Trauma/Medical/Chiropractic and Healing History: Have you ever injured your spine (neck, head, back, hips)?

Date of most significant injury: What happened?

Date of most recent injury: What happened?

6. Have you taken any medications (prescription or non-prescription) within the last 60 days?

Yes No

7. If yes, please list them:

8. In the past, have you taken any other medications for a period of more than 3 months?

Yes No

9. What did you take?

What were the reasons for taking them and for how long did you take them?

10. Have you had any spinal X-rays, CT scans or MRI imaging of your spine (neck, back, hips)?

When?

Why?

What were you told regarding them?

Where are the films now?

11. Have you had any surgeries? Please explain?

12. Have you broken any bones, or significantly sprained a part of your body

Yes

No

13. Please explain:

14. Please list any herbs, nutritional supplements or natural remedies you take regularly:

15. Have you consulted a physician, or any health care provider within the past 3 months? What for?

16. Has your spine ever been professionally adjusted/manipulated/entrained?

Yes

No

17. Please explain:

By whom and when?

Why did you go?

Are you still going?

What did he/she do for you?

Did you feel it worked/were you pleased with the results?

18. Do you consult with a physician for anything other than routine evaluations?

Yes

No

19. What is/was the reason for the visit(s)?

When was your last visit

What was done or suggested?

20. Have you had experience with the following health, treatment or healing modalities? If so, please describe when you went, for how long you went and what the results were:

Massage/Bodywork:

Emotional Therapy/ Psychotherapy:

Music/Dance/Sound/Light/Aromatherapy:

Homeotherapy/Herbalist:

Ayurvedic Medicine:

Oriental Medicine/ Acupuncture:

Nutritional Counseling/ Therapy:

Oxygen Therapy/Chelation Therapy:

Rebirthing/Breath work:

Yoga/Movement/Dance/Tai Chi/Chi Gong:

Somato Respiratory Integration:

Other:

21. Do you have an exercise, meditation, prayer, nutritional or dietary program? Please describe:

22. When stressed, how do you "center yourself" or "re-group"?

23. Part 3: Stress Survey: Please grade the following stresses in order of increasing intensity; this is over the span of your entire life, not just the present time.

24. Part 3: Stress Survey: Please grade the following stresses in order of increasing intensity; this is over the span of your entire life, not just the present time. 0- no awareness of stress 1-slightly stressful situation 2- moderately stressful situation 3- extremely stressful situation

	0	1	2	3
Overall physical stress/trauma: Includes: falls, accidents, injuries, repeated postural stress impacts, difficult birth, traction, and physical abuse.				
Overall emotional/mental stress: Includes: loss of loved ones, rapid change in life situation, mental, emotional, or sexual abuse, legal concerns, financial concerns, move of home/school, separation/divorce etc. in relationship, stress of being ill etc.				
Overall chemical stress: Includes: drugs, smoke, fumes, food additives, pollution, prescription drug use etc.				

25. Have you ever been in a work or vehicle related injury? Please describe:

26. Additional Comments or things that you feel Dr. DeFino should know:
