POJERO FAMILY CHIROPRACTIC

PERSONAL HEALTH HISTORY

Date ______________________

Name ____________________________________ Case No. ______________________

Address ______________________________City/State/Zip______________________

Date Of Birth __________________________ SS# ______________________________

Home Phone # _________________________ Work Phone # ______________________

Name Of Employer ____________________________ Occupation ________________

Marital Status ____________________________

Spouse's Name ____________________ Spouse's Age ___________________________

Children's Names and Ages ____

____

Hobbies ____

Who Referred You ____

Name Of Previous Chiropractors _______________ When Was Your Last Visit? _________

For How Long Were You Receiving Chiropractic Adjustments? ________________________

Reason For Coming In ____

What accidents have you had (ex. bicycle, car, motorcycle, sports, slips/falls) at work or at home (include dates) ____

____

Were you ever knocked unconscious? _______________________________________

What fractures or broken bones have you had? (include dates) _______________________

____

SURGERY :

What major surgery have you had? (included dates) ________________________________

____

What minor surgery have you had? (tonsillectomy, appendectomy, wart/cyst removal, dental extraction) ____

MEDICATION :

Present Prescription Drugs	Past Prescription Drugs	Over-The-Counter Drugs (aspirin, cold tablets, cough syrup, laxatives, etc)
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________

THERAPY:

Are you presently under any therapeutic care? (what type) ________________________________

What therapeutic care have you been under in the past (radio, chemo, physio, electro, etc., include dates) ____

YOUR BIRTH RECORD :

Type of birth (Vaginal, Cesarean, etc.) ____

Any complications during your mothers pregnancy or during your birth? _______________________

Any complications after your birth ____

CURRENT HEALTH:

How would you describe your current health? ____

How would you describe your family's health? ____

Describe your: Vision _____________ Hearing _______________ Coordination _________________

Do you use any of the following: Tobacco Alcohol coffee/tea cola milk

Level of stress in your life: mild moderate extreme 1 2 3 4 5 6 7 8 9 10

Do you purchase any of the following: **Bottled Drinking Water** : ( ) No ( ) Yes

Vitamins: ( ) No ( ) Yes **Health Food Products** (organic products, etc.): ( ) No ( ) Yes

FINANCIAL INFORMATION:

Who is responsible for this account? ______________________________ Relationship _____________

Date of Birth ________________ SS# ____________________ Employer ___________________________

What method of payment will you be using ? Insurance Cash Check Other

Name of Insurance Company __________________________________ Policy # ____________________

Please check any of the following that give you difficulty or you have had recently

__ **Headaches 784.0**	__**Fainting 780.2**	__ **Shortness of breath 786.09**	__ **Numbness in legs/feet 782**
__ **Shooting head pains 784.0**	__ **Loss of balance 781.2**	__ **Mid-back pain 724.1**	__ **Constipation 564.0**
__ **Sinus trouble 473.9**	__ **Ringing in the ears 388.3**	__ **Heart attack 410.9**	__ **Kidney trouble 593.9**
__ **Loss of smell 781.1**	__ **Blurred vision 368.0**	__ **Low blood pressure 458.9**	__ **Menstrual cramp/pain 625.3**
__ **Allergies 995.3**	__ **Lights bother eyes 368.13**	__ **High blood pressure 401.9**	__ **Menstrual irregularity 626.4**
__ **Hayfever 477.8**	__ **Neck pain 723.1**	__ **Anemia 285.9**	__ **Diabetes 250.0**
__ **Asthma 493.9**	__ **Muscle spasms in neck 781**	__ **Stomach trouble 789**	__ **Sleeping problems 780.5**
__ **Loss of taste 781.1**	__ **Grinding in neck 719.4**	__ **Nerves/Nervousness 799.2**	__ **Painful joints 719.4**
__ **Inflammation of throat 462**	__ **Shoulder/arm tight 728.85**	__ **Inner Tension 799.2**	__ **Swollen joints 719.0**
__ **Thyroid trouble 246.9**	__ **Shoulder/arm pain 719.4**	__ **Irritability 799.2**	__ **Pins & needles in leg 782**
__ **Facial Twitch 781.0**	__ **Pins & needles in arm 782**	__ **Gall bladder trouble 575.9**	__ **Swollen ankles 782.3**
__**Loss of Memory** _____	__ **Pins & needles in hands 782**	__ **Indigestion 536.8**	__ **Cold feet 782**
__ **Fatigue 780.7**	__ **Cold hands 782**	__ **Intestinal Gas 787.3**	__ **Pain in legs/feet 719.46**
__ **Depression 311.0**	__ **Numbness in arm/hand 782**	__ **Low back pain 724.2**	__ **Hip pain 719.45**
__ **Dizziness 780.4**	__ **Tonsillitis 784**	__ **Sciatic pain**	__ **Facial pain 784.0**
__ **Spinal curvature 737.43**	__ **Prostate trouble 601.4**	__ **Stroke 436.0**	__ **Jaw pain (TMJ) 525.9**
__ **Chest pain 786.5**	__ **Bed wetting 788.3**	__ **Arthritis 716.96**	__ **Ulcers 534.9**
__ **Earache**	__ **Cancer**	__ **Seizures**	__ **Hernia 550.1**