

Life Chiropractic

Personal Health History

Date: _____ Name: _____ Spouse's name: _____

Address: _____

City: _____ State: _____ Zip: _____ CA Driver's License _____

Home phone: _____ Work phone: _____ Birth date: _____ Age: _____

Business/Employer: _____ Type of work: _____

Sex: M F Check one: Single Married Divorced Separated Widow Number of children _____

Name of parent if minor: _____ Phone # _____

Referred by: _____

Who is responsible for your bill? Self Spouse Worker's Comp. Medicare Auto insurance
Personal Health insurance Medi-Cal Other _____

Method of Payment for Initial Visit Charges: Cash Check Visa MC

Name of Insurance co.: _____

Phone # of Insurance co.: _____ Your policy # _____

Name policy is under: _____ Place of Employment _____

Purpose of this Appointment: _____

Other Doctors seen for this condition: _____

When did this condition begin: _____ Is it Job related Auto related Home accident

Drugs you now take: Nerve pills Pain killers Muscle relaxers Blood pressure pills Insulin

Other/Over-the-Counter: _____ Women only: Are you pregnant? Yes No

Major Surgery/Operations: Appendectomy Tonsillectomy Gall Bladder Hernia Spinal Hysterectomy

Broken Bones Other: _____

Accidents/Falls History (such as auto/work/sport-related/jolts/trauma/etc.): **IMPORTANT INFORMATION...**

All events which could have any impact upon the spine are of high significance to determine spinal health history. Please fill out completely.

Within the past year - when: _____

Describe event: _____

Over a year ago - when: _____

Describe event: _____

Childhood - when: _____

Describe event: _____

Hospitalizations (other than above): _____

Previous Chiropractic Care: No Yes: where/when _____

Do You Purchase Any of the Following: **Bottled Drinking Water:** No Yes **Vitamins:** No Yes

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

Are You a Member of a Gym or Health Club: No Yes

Signed _____ Date _____ Witness _____

(If under age 18) parent's signature _____