Chiani Chiropractic

Dr. Joanne Welham, BA, DC

Health History

First Name _____ **Initial**____ **Last Name** _____

Care Card # _____ **Date of Birth (M/D/Y)** _____

Address _____

City / Province_____ Postal Code _____

Mailing Address (if different from above)_____

Email Address _____

Home Phone_____ Work Phone _____ Cell Phone _____

Occupation _____ Employer_____

Spouse _____ Children (names / ages) _____

Contact in an emergency_____Phone_____Relation to you_____

Who referred you to us? _____

Or, how did you choose us? _____

Past Chiropractic Care? Yes ☐ **No** ☐

Chiropractor's name / location _____ Last Visit _____

Current Medical Care: Doctor's name _____ **Location** _____

Do you have insurance coverage? Company? _____ **Policy #** _____ **Group #** _____

Policy Holders Name: _____ **Policy Holders DOB:** _____

- The human body is designed to express health and function normally; however, events may occur in life that can *interfere* with this natural ability.
- This interference is most commonly caused by *vertebral subluxations*, resulting from *physical*, *chemical*, or *emotional stress*.
- The practice of *chiropractic* is based on locating and reducing the vertebral subluxation, which causes nerve system interference.

Please check the *ONE* choice that most closely describes your current goals for health and well-being.

☐ I am concerned about relief of a particular symptom.

☐ I am concerned about relief of a particular symptom, and preventing its return.

☐ I want optimum health and well-being on every level available to me.

PRESENT STATE OF HEALTH

1) What is the purpose of this appointment?_____
2) What is the area of concern? _____
3) When did this condition begin? _____
4) How did it begin? _____
5) Has this condition occurred before? _____
6) Have you had prior treatment for the condition? No_____ Yes_____
7) When and by whom? _____
8) How would you describe your condition? _____

   _____
9) Do you have any other complaints that you would like to work on? _____

   _____

PAST HEALTH HISTORY INCLUDING CHILDHOOD

1) Have you ever had X-Rays? No _____ Yes_____
2) Which body parts and when? _____
3) Have you ever had any of the following:
   - Surgeries/operations? What? When? _____
   - Hospitalizations? What? When?_____
   - Broken bones? Which ones and when? _____
   - Any accidents or falls/injuries? When? _____
   - Major sickness/illness? What? When? _____
   - Any automobile accidents? When? _____
4) Do you take any prescription or non-prescription medications? No _____ Yes _____
   - What kinds? _____
5) Have you ever experienced any complications with any of the following systems?
   - Nerve or Nervous System? If so, what type? _____
   - Digestive problems? If so, what type? _____
   - Muscle, Bone or Joint conditions? If so, what type? _____
   - Chest or Respiratory? If so, what type? _____
   - Genital Or Urinary? If so, what type? _____
6) Other health related problems? _____
7) Anything else you would like your doctor to know? _____

   _____

Signature_____ Date_____