Hansen Chiropractic Wellness Center

Confidential Patient Case History

Name: _____ SSN: _____ Date of Birth: _____

Address: _____
Residence and mailing City State Zip

Home Telephone: ( ) _____ Work Phone ( ) _____

E-Mail Address: _____ Male _____ Female _____

Occupation/Employer's Name: _____

Single __ Married __ Divorced __ Widowed __ Spouse's Name/Employer: _____

Reason for consulting our office? _____

Who may we thank for referring you to our office? _____

YOUR HEALTH PROFILE

WHY THIS FORM IS IMPORTANT

As a full spectrum Chiropractic office, we focus on your ability to be healthy. Our goals are, first, to address the issues that brought you to this office, and second, to offer you the opportunity of improved health potential and wellness services in the future. On a daily basis we experience physical, chemical, and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual, not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses you have faced in you lifetime, allowing us to better assess the challenges to your health.

THE BEGINNING YEARS (TO AGE 17)

Research is showing that many of the health challenges that occur later in life have their origins during the developmental years, some starting at birth. Please answer the following questions to the best of your ability.

YOUR CHILDHOOD YEARS

	YES	NO	UNSURE
Did you have any childhood illnesses?	☐	☐	☐
Did you have any serious falls as a child?	☐	☐	☐
Did you play youth sports?	☐	☐	☐
Did you take / use any drugs?	☐	☐	☐
Did you have surgery?	☐	☐	☐
Have you fallen / jumped from a height over three feet? (i.e. crib, bunk bed, trees)	☐	☐	☐
Were you involved in any car accidents as a child?	☐	☐	☐

	YES	NO	UNSURE
Was there any prolonged use of medicine such as antibiotics or an inhaler?	☐	☐	☐
Did you suffer any other traumas? (physical or emotional)	☐	☐	☐
Were you vaccinated?	☐	☐	☐
As a child, were you under regular Chiropractic care?	☐	☐	☐

COMMENTS: _____

_____

Adult - (18 TO PRESENT)

	YES	NO
Do / did you smoke?	☐	☐
Do / did you drink alcohol?	☐	☐
Have you been in any accidents?	☐	☐
Have you had any surgeries?	☐	☐

	YES	NO
Do / did you play any adult sports?	☐	☐
Do / did you participate in extreme sports?	☐	☐

On a scale of 1 - 10 describe you stress level:
(1 = none / 10 = Extreme)
Occupational _____
Personal _____

On a scale of Poor, Good, Excellent, describe your:

Diet _____ Exercise _____ Sleep _____ General Health _____

Addressing The Issues That Brought You To The Office

If you have no symptoms or complaints, and are here for wellness services, please check (√) here _____ **"Wish to have Chiropractic Wellness Services"** and skip to **"Family Health Profile"**. Others need to briefly describe the chief area of complaint, including the effect it has had on your life.

_____

_____

If you are experiencing pain, is it...

☐ Sharp ☐ Dull ☐ Comes and goes ☐ Travels ☐ Constant

Since the problem started, it is... ☐ About the same ☐ Getting Better ☐ Getting Worse

What makes it worse: _____

Yes, it interferes with: ☐ Work ☐ Sleep ☐ Walking ☐ Sitting ☐ Hobbies ☐ Leisure

Other Doctors seen for this problem (please list)

☐ Chiropractor _____

☐ Medical Doctor _____

☐ Other _____

Please check (√) all symptoms you have ever had, even if they do not seem related to your current problem.

☐ Headaches	☐ Pins and needles in legs	☐ Fainting	☐ Neck pain
☐ Pins and needles in arms	☐ Loss of smell	☐ Back pain	☐ Loss of balance
☐ Dizziness	☐ Buzzing in ears	☐ Ringing in ears	☐ Nervousness
☐ Numbness in fingers	☐ Numbness in toes	☐ Loss of taste	☐ Stomach upset
☐ Fatigue	☐ Depression	☐ Irritability	☐ Tension
☐ Sleeping problems	☐ Neck stiff	☐ Cold hands	☐ Cold feet
☐ Diarrhea	☐ Constipation	☐ Fever	☐ Hot flashes
☐ Cold sweats	☐ Lights bother eyes	☐ Problem urinating	☐ Heartburn
☐ Mood swings	☐ Menstrual pain	☐ Menstrual irregularity	☐ Ulcers

List any medications you are taking _____

_____

Family Health Profile:

At our office we are not only interested in your health and well-being, but also the health and well-being of your family and loved ones. Please mention below any health conditions or concerns you may have about your:

Children _____

Spouse _____

Mother _____

Father _____

Brothers _____

Sisters _____

Other _____

Have you ever:

Bought bottled water: ☐ **YES** ☐ **NO**

Belonged to a health club: ☐ **YES** ☐ **NO**

Consumed vitamins or supplements: ☐ **YES** ☐ **NO**

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

_____ _____

Signature Date