PERSONAL HISTORY QUESTIONNAIRE

Date: ____/____/____

Name: ______________________ Address: ______________________

City: ____________ State: ________ Zip: ________ Occupation: ____________

E-Mail: ____________ Home Phone: ____________ Business Phone: ____________

Date of Birth: ________ Age: ______ ❐ M ❐ F Marital Status: ____________ No. of Children: ______

Social Security Number:(optional) ____________ Insurance: ____________

How did you hear about our office? ______________________

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT YOUR PERSONAL HISTORY:

1. Have you ever had your spine or nervous system examined professionally? ❐Yes ❐No

2. Have you ever received Network Spinal Analysis care? ❐Yes ❐No Network Chiropractic care? ❐Yes ❐No

   If yes, when was your last visit? ________ For how long were you going? ____________

   How often did you go? ____________ If you stopped, why did you stop going? ____________

3. Were you pleased with his or her service? ❐Yes ❐No

4. Does your immediate family receive Network Care? ❐Yes ❐No

5. Have you had, or do you receive the following vehicles towards healing or growth?
   If yes, please list when and any comments you wish to share:

   Chiropractic: ❐Yes ❐No ______________________

   Bodywork / massage: ❐Yes ❐No ______________________

   Osteopathy / cranial work: ❐Yes ❐No ______________________

   Homeopathy/Accupuncture: ❐Yes ❐No ______________________

   Meditation: ❐Yes ❐No ______________________

   Psychotherapy: ❐Yes ❐No ______________________

   Movement or exercise: ❐Yes ❐No ______________________

   Somato Respiratory Integration: ❐Yes ❐No ______________________

   Yoga: ❐Yes ❐No Prayer: ❐Yes ❐No Other: ______________________

   Rebirthing / breathwork: ❐Yes ❐No ______________________

6. Do you currently have any health concerns? ❐Yes ❐No Please describe: ______________________

   ____

7. What do you hope to gain from the care in this office? ______________________

   ____

The practice of chiropractic is based upon the location and adjustment of vertebral subluxations. Subluxations are caused by any stress your body can not properly perceive, adapt to or recover from. These stresses may be PHYSICAL, CHEMICAL, or EMOTIONAL in nature.

PHYSICAL HISTORY - BIRTH STRESS: If you have Information about your birth history:

1. Was your mother outwardly ill prior to her pregnancy with you? ☐Yes ☐No
2. Did your mother have a difficult pregnancy with you? ☐Yes ☐No
3. Did your mother have any falls, accidents or physical injuries during pregnancy? ☐Yes ☐No
4. Was your birth traumatic? ☐Yes ☐No
5. Was your birth: ☐drug induced ☐forceps or suction ☐"C" section ☐Cord around the neck ☐breech ☐prolonged ☐Natural ☐Other: ____________
6. Describe any other physical or mechanical stress to your mother or you as labor progressed, delivery progressed, or as a newborn.

____

GENERAL PHYSICAL TRAUMA:

7. Next to each potential vertebral subluxation cause is a check box. Please check the appropriate box - either 'P' for past or 'C' for current, and the correct level of trauma: Mild, Moderate, or Extreme.

	MILD		MODERATE		EXTREME			MILD		MODERATE		EXTREME	
	P	C	P	C	P	C		P	C	P	C	P	C
Falls from crib, carriage	☐	☐	☐	☐	☐	☐	Sports impacts	☐	☐	☐	☐	☐	☐
Falls down or up steps	☐	☐	☐	☐	☐	☐	Physical fight	☐	☐	☐	☐	☐	☐
Falls on ice	☐	☐	☐	☐	☐	☐	Armed services	☐	☐	☐	☐	☐	☐

Comments: ____________

8. Were you ever knocked unconscious? ☐Yes ☐No

   Comments: ____________

9. Have you ever used crutches, a walker, or cane? ☐Yes ☐No

   Comments: ____________

10. Have you ever broken any bones? ☐Yes ☐No

    Comments: ____________

11. Have you ever had any impacts, falls, or jolts that you feel specifically may have injured your spine? ☐Yes ☐No

    Comments: ____________

12. Have you had extensive dental or orthodontial work performed? ☐Yes ☐No

    Comments: ____________

13. Have you served in the military? ☐Yes ☐No From________ to__________ Were you involved in combat? ☐Yes ☐No
14. During the day I: ☐sit ☐stand ☐walk ☐do desk work ☐phone work ☐drive ☐do mechanical work ☐heavy lifting
15. I exercise: ☐daily ☐weekly ☐monthly Describe: ____________

SPORTS or LEISURE:

16. Were you, or are you active in any particular sport(s)? ☐Yes ☐No

    Which one(s)? ____________

17. Have you been hurt in any of these activities? ☐Yes ☐No

    Comments: ____________

18 Do you read for prolonged periods? ❒Yes ❒No

19 Do you play a musical instrument? ❒Yes ❒No

20 Do you have a particular position for watching television? ❒Yes ❒No

Comments: ______________________________

21 I wear: ❒Glasses ❒Bifocals ❒Contact lenses

AUTOMOBILE ACCIDENTS:

22 Have you, (even as a passenger, even if you do not think you were hurt), been involved in a vehicular collision, or near collision? Please list approximate dates and severity (Mild, Moderate or Extreme).

Automobile: ______________________________

____

Bus, bicycle, motorcycle, train, airplane, moped, or other vehicles: ______________________________

____

MEDICAL TREATMENT:

23 Have you ever been hospitalized? ❒ Yes ❒ No If yes, what was actually done to you? ______________________________

24 Have you had surgery? ______________________________

25 Do you still have all your body parts? ______________________________

26 Have you had: ❒ a spinal tap ❒ spinal injections ❒ physiotherapy ❒ neck collar ❒ spinal brace ❒ traction ❒ heel lift ❒ x - ray treatments ❒ corrective shoes or bars on shoes ❒ extensive diagnostic x - rays ❒ acupuncture ❒ chemotherapy ❒ transfusion ❒ body part in a cast or immobilized?

CHEMICAL HISTORY - BIRTH STRESS:

1 Was your mother regularly taking any drug immediately prior to, or during her pregnancy with you? ❒ Alcohol ❒ Smoking

Other?: ______________________________

2 Was her labor chemically induced or altered? ❒ Yes ❒ No

3 Was your mother: ❒ conscious ❒ semiconscious ❒ unconscious during your delivery? ❒ Under spinal anesthesia during delivery?

4 Any other chemical stress that your mother may have been subject to during pregnancy or labor?: ______________________________

GENERAL CHEMICAL TRAUMA:

5 Are you now taking any drug (prescription or over-the-counter) regularly? Please list drugs, when prescribed and reasons for taking them: ______________________________

____

Are these drugs being prescribed by a physician? ❒Yes ❒No Last visit: ______________________________

6 If you were previously taking any medication regularly? Please describe: ______________________________

____

7 Do you or did you work with any chemical, fume, dust, powder, smoke for prolonged periods? ❒Yes ❒No

8. Please grade any dietary selection that is appropriate for you using the following scale:

O - Do not consume this
M - Consume this monthly
FM - Consume a few times per month (less than weekly)
FD - Consume this a few times per day
W - Consume this weekly
FW - Consume this a few times per week
D - Consume this daily

_______ Alcohol
_______ Coffee
_______ Tobacco
_______ Artificial Sweeteners
_______ Soda
_______ Diet Food
_______ Refined Sugar
_______ Eggs
_______ Cooked, canned vegetables
_______ Raw Vegetables
_______ Fruit
_______ Whole Grains
_______ Dairy (milk products)
_______ Fried Foods
_______ Beef
_______ Poultry
_______ Fish
_______ Seafood
_______ Weight Control Diet
_______ Fasting
_______ Organic Foods

The type of diet I usually follow is classified as: ____________________

EMOTIONAL HISTORY - BIRTH STRESS:

1. My birth was: ☐ at home ☐ in a birthing center ☐ in a hospital ☐ other

2. Were you incubated or isolated after birth? ☐ Yes ☐ No

3. Were you ☐ bottle fed formula ☐ bottle fed mother's milk ☐ nursed ☐ nursed and bottle fed?

GENERAL EMOTIONAL TRAUMA:

4. With each of the following potential spinal stress situations, please check either "P" for past or "C" for current.

	MILD		MODERATE		EXTREME	
	P	C	P	C	P	C
Childhood stress	☐	☐	☐	☐	☐	☐
School stress	☐	☐	☐	☐	☐	☐
Play, or recreational	☐	☐	☐	☐	☐	☐
Family stress	☐	☐	☐	☐	☐	☐
Personal relationships	☐	☐	☐	☐	☐	☐
Stress of being sick	☐	☐	☐	☐	☐	☐
Work related stress	☐	☐	☐	☐	☐	☐
Stress of commuting	☐	☐	☐	☐	☐	☐
Loss of loved one	☐	☐	☐	☐	☐	☐
Change in lifestyle	☐	☐	☐	☐	☐	☐
Change in vocation	☐	☐	☐	☐	☐	☐
Abuse	☐	☐	☐	☐	☐	☐

5. How do you grade your physical health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Getting Better ☐ Getting Worse

6. How do you grade your emotional/mental health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Getting Better ☐ Getting Worse

7. If you consider yourself ill, why do you feel you are ill? ____________________

8. If you consider yourself well, why do you feel you are well? ____________________

9. Is there anything else you may wish to share which may help us to better understand you, and why you have chosen to see the doctor in this office? ____________________

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