PERSONAL HISTORY

Date: _____

Name: _____ **Address:**_____

City: _____ **State:** _____ **Zip:**_____ **Home Phone:** _____

Work phone: _____**Cell Phone:**_____ **E-Mail:**_____

Employer:_____ **Type of work:** _____

Employers address: _____

Birth date: _____ **Sex:**_____ **Height:** _____ **Weight:** _____

Are you: Married___ **Single**___ **Widowed**___ **Divorced**___ **Separated**___

Ages of children: _____

Emergency contact: _____ **Phone number:**_____

Referred to this office by friend or relative _____ **Phone book** ☐

Insurance Co. ☐ **Internet** ☐ **Other** _____

Please check type of care you desire

☐ **Temporary symptom relief** ☐ **Lasting correction and maintenance** ☐ **General overall health maintenance**

Please describe any accidents or falls You have had:

Fractures or dislocations:

Habits: Sleep(hours)_____ **Coffee**☐ **Tea** ☐ **Alcohol** ☐ **Tobacco** ☐

Exercise_____ **Hobbies** _____

Have you ever had a nervous breakdown _____

Have you or a family member ever been treated for a mental disorder_____

Have you been under a lot of stress (please explain)_____

_____

List medications you are taking_____

List vitamins you are taking_____

Do you have a family medical doctor ☐**No** ☐**Yes Name**_____

Have you seen a Chiropractor in the past ☐**No**☐**Yes Name**_____