



# bellies babies and beyond

chiropractic

Dr. Beth Hoffman, D.C.

## Health History Form

### Personal Information

Full Name \_\_\_\_\_ Date \_\_\_\_\_

Mailing address \_\_\_\_\_

Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_

Cell Phone ( ) \_\_\_\_\_ Best time and place to contact you \_\_\_\_\_

Is it ok to leave voice mail messages? Y N Is it ok to send mailings? Y N

Spouse/Guardian Name \_\_\_\_\_

Marital Status: M S W D Age \_\_\_\_\_ Birth date \_\_\_\_\_ No. of children \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Occupation \_\_\_\_\_

Employer's Name and Address \_\_\_\_\_

Spouse Occupation/Employer \_\_\_\_\_

Name of person responsible for account \_\_\_\_\_

Email address: \_\_\_\_\_

WHO MAY WE THANK FOR REFERRING YOU? \_\_\_\_\_

### ADDRESSING WHAT BROUGHT YOU INTO THIS OFFICE:

If you have no symptoms or complaints and are here for Chiropractic Wellness Services, please skip to the "General History" section

### HEALTH CONCERNS

List health concerns according to their severity	Rate of severity 1= mild 10= worst imaginable	When did this episode start?	If you had the condition before, when?	Did problem begin with an injury?	% of time pain is present
1. _____	_____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____	_____

What have you done for this condition? Was it of benefit?  
\_\_\_\_\_  
\_\_\_\_\_

I do (do not) have a family history of this or similar symptoms (Please explain)  
\_\_\_\_\_  
\_\_\_\_\_

What activities aggravate your condition? \_\_\_\_\_  
\_\_\_\_\_

Other Doctor's seen for this condition: "Limited Scope" Chiropractor (Focuses mainly on neck and back pain) \_\_\_\_\_  
"Wellness" Chiropractor (focuses on health and well being as well as underlying cause of pain and health concerns) \_\_\_\_\_  
Medical Dr. \_\_\_\_\_ Dentist \_\_\_\_\_ Other \_\_\_\_\_

1. Name/Address: \_\_\_\_\_  
When: \_\_\_\_\_ What did they say was wrong? \_\_\_\_\_  
What did they do? \_\_\_\_\_ Did it help? \_\_\_\_\_

2. Name/Address: \_\_\_\_\_  
When: \_\_\_\_\_ What did they say was wrong? \_\_\_\_\_  
What did they do? \_\_\_\_\_ Did it help? \_\_\_\_\_

Have you been "forced" or "felt the need" to make any "positive" changes in your life due to this pain, illness, condition, etc? (i.e., eat better, less alcohol or drugs, meditate or breathe more, less destructive sports, activities, etc.) If so, what?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is this condition interfering with your: work \_\_\_\_\_ sleep \_\_\_\_\_ daily routine \_\_\_\_\_ sports/exercise \_\_\_\_\_  
Other \_\_\_\_\_

Are you unable to do certain activities that you would like to do because of this pain, illness, condition? (i.e. sports, walk, pick up grandchildren, etc.) If so, what?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**IF YOUR CONDITION IS LOW BACK RELATED PLEASE ANSWER THE FOLLOWING:**

Does this pain wake you up at night? \_\_\_\_\_  
Have you had any unexplained weight loss? \_\_\_\_\_  
Have you had any fevers? \_\_\_\_\_  
Have you had any recent infections? \_\_\_\_\_  
Do you have an immune compromised system? \_\_\_\_\_  
Urinary incontinence? \_\_\_\_\_  
Numbness on inner thighs? \_\_\_\_\_  
Prolonged use of Corticosteroids? \_\_\_\_\_

What lesson(s) have you taken home from your healing process to date?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PRENATAL HEALTH HISTORY**

Are you currently pregnant? Y N weeks? \_\_\_\_\_  
Is this your first pregnancy? Y N  
Who is your obstetrician/midwife? \_\_\_\_\_  
Have you had any trauma during this pregnancy? \_\_\_\_\_  
Have you had ultrasounds during this pregnancy? Y N How many? \_\_\_\_\_  
Have you consumed alcohol and /or cigarettes during this pregnancy? Y N  
Do you plan to have a birth plan? \_\_\_\_\_  
Have you had any complications during this pregnancy? \_\_\_\_\_  
Do you plan to breastfeed? Y N  
Do you plan to have a birth assistant or doula present at the birth? Y N  
What "special" care are you providing yourself to benefit your pregnancy? (ex. Massage, yoga, meditation...)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**GENERAL HEALTH HISTORY SECTION**

Have you had any surgery? (Please include all surgery)

- 1. Type \_\_\_\_\_ When \_\_\_\_\_ Doctor \_\_\_\_\_
- 2. Type \_\_\_\_\_ When \_\_\_\_\_ Doctor \_\_\_\_\_
- 3. Type \_\_\_\_\_ When \_\_\_\_\_ Doctor \_\_\_\_\_
- 4. Type \_\_\_\_\_ When \_\_\_\_\_ Doctor \_\_\_\_\_

Have you had any serious illness or health concerns? Please list condition and date of diagnosis

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Accidents and/or injuries: auto, work related or other (Especially those related to your present problems).

- 1. Type \_\_\_\_\_ When \_\_\_\_\_ Hospitalized \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_
- 2. Type \_\_\_\_\_ When \_\_\_\_\_ Hospitalized \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_
- 3. Type \_\_\_\_\_ When \_\_\_\_\_ Hospitalized \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_

Have you ever had x-rays taken? \_\_\_\_\_ When? \_\_\_\_\_ Where? \_\_\_\_\_

Area of body: \_\_\_\_\_

Do you wear orthotics or heel lifts? Yes \_\_\_\_\_ No \_\_\_\_\_

**CURRENT MEDICINE(S)/SUPPLIMENTS:**

Please list any medications/drugs you have taken in the past 6 months and why: (prescription and non-prescription)

\_\_\_\_\_

\_\_\_\_\_

Please list all nutritional supplements, vitamins, homeopathic remedies you presently take and why:

\_\_\_\_\_

\_\_\_\_\_

Are you interested in knowing more about how your nutrition (food you eat) affects your overall health and well-being?

YES \_\_\_\_\_ NO \_\_\_\_\_ MAYBE \_\_\_\_\_

If dietary changes are indicated would you be willing to make changes in your diet?

YES \_\_\_\_\_ NO \_\_\_\_\_ MAYBE \_\_\_\_\_

Would you take whole food supplements if indicated?

YES \_\_\_\_\_ NO \_\_\_\_\_ MAYBE \_\_\_\_\_

**Diet:**

Please circle any dietary selection that is appropriate for you, and grade according to the following scale:

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

- Alcohol \_\_\_\_\_ Eggs \_\_\_\_\_ Fasting \_\_\_\_\_ Artificial Sweetener \_\_\_\_\_
- Tobacco \_\_\_\_\_ Fruit \_\_\_\_\_ Diet Food \_\_\_\_\_ Weight Control Diet \_\_\_\_\_
- Coffee \_\_\_\_\_ Beef \_\_\_\_\_ Refined Sugar \_\_\_\_\_ Raw Vegetables \_\_\_\_\_
- Soda \_\_\_\_\_ Poultry \_\_\_\_\_ Fish \_\_\_\_\_ Whole Grains \_\_\_\_\_
- Fried Foods \_\_\_\_\_ Cooked, canned vegetables \_\_\_\_\_ Seafood \_\_\_\_\_
- Dairy \_\_\_\_\_ Organic Foods \_\_\_\_\_ Fast food \_\_\_\_\_

The type of diet I usually follow is classified as: \_\_\_\_\_

**PAST HEALTH HISTORY:**

Mark the following conditions you may have had or have now (- have had +have now)

- |   |  |                                       |   |                                     |  |
|---|--|---------------------------------------|---|-------------------------------------|--|
| <input type="checkbox"/> Allergy                | <input type="checkbox"/> Diarrhea          | <input type="checkbox"/> Measles      | <input type="checkbox"/> Rheumatic Fever    | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Eczema        |
| <input type="checkbox"/> Miscarriage            | <input type="checkbox"/> Stroke            | <input type="checkbox"/> Anemia       | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> HIV (Aids) | <input type="checkbox"/> Gout          |
| <input type="checkbox"/> Arteriosclerosis       | <input type="checkbox"/> Emphysema         | <input type="checkbox"/> Mumps        | <input type="checkbox"/> Sinus Problems     | <input type="checkbox"/> Arthritis  | <input type="checkbox"/> Neuritis      |
| <input type="checkbox"/> High Blood Pressure    | <input type="checkbox"/> Asthma            | <input type="checkbox"/> Nervousness  | <input type="checkbox"/> Thyroid Problems   | <input type="checkbox"/> Ulcers     | <input type="checkbox"/> Cancer        |
| <input type="checkbox"/> Heart Disease          | <input type="checkbox"/> Depression        | <input type="checkbox"/> Convulsions  | <input type="checkbox"/> Venereal Disease   | <input type="checkbox"/> Malaria    | <input type="checkbox"/> Pleurisy      |
| <input type="checkbox"/> Constipation           | <input type="checkbox"/> Pneumonia         | <input type="checkbox"/> Cold Sores   | <input type="checkbox"/> Whooping Cough     | <input type="checkbox"/> Polio      | <input type="checkbox"/> Neck Pain     |
| <input type="checkbox"/> Gall Bladder Problems  | <input type="checkbox"/> Migraines         | <input type="checkbox"/> Headaches    | <input type="checkbox"/> Menstrual Cramps   | <input type="checkbox"/> Back Pain  | <input type="checkbox"/> Epilepsy      |
| <input type="checkbox"/> Irregular Periods      | <input type="checkbox"/> Diabetes          | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Heart Attack       | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Vision change |
| <input type="checkbox"/> Low Blood Sugar        | <input type="checkbox"/> Ringing in ears   | <input type="checkbox"/> Cough        | <input type="checkbox"/> Infertility        | <input type="checkbox"/> Wheezing   | <input type="checkbox"/> nausea        |
| <input type="checkbox"/> Frequent Urination     | <input type="checkbox"/> Painful Urination |                                       |   |                                     |  |
| <input type="checkbox"/> Other (please explain) |  |                                       |   |                                     |  |

**Please list your top three stresses in each category:**

1. Physical stress (falls, accidents, work postures, etc.)
  - a. \_\_\_\_\_
  - b. \_\_\_\_\_
  - c. \_\_\_\_\_
2. Bio-chemical stress (smoke, unhealthy foods, missed meals, don't drink enough water, drugs/alcohol, etc.)
  - a. \_\_\_\_\_
  - b. \_\_\_\_\_
  - c. \_\_\_\_\_
3. Psychological stress (work, relationships, finances, self-esteem, etc.)
  - a. \_\_\_\_\_
  - b. \_\_\_\_\_
  - c. \_\_\_\_\_

How do you grade your physical health? Excellent\_\_\_ Good\_\_\_ Fair\_\_\_ Poor\_\_\_ Getting better\_\_\_ getting worse\_\_\_

How do you grade your emotional/mental health? Excellent\_\_\_ Good\_\_\_ Fair\_\_\_ Poor\_\_\_ Getting better\_\_\_ getting worse\_\_\_

Is there anything else which may help to better understand you which have not been discussed?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Why are you here at this point in time?

\_\_\_\_\_  
\_\_\_\_\_

**FAMILY HEALTH**

Please answer the following questions regarding your family health history. (Self, grandparents, parents and siblings only)

Has anyone had?

Cancer? \_\_\_\_\_

Diabetes? \_\_\_\_\_

Heart Disease? \_\_\_\_\_

Stroke? \_\_\_\_\_

Arthritis? \_\_\_\_\_

Osteoporosis? \_\_\_\_\_

I consent to a professional and complete chiropractic examination.

Print Patient Name \_\_\_\_\_ Date: \_\_\_\_\_

Signature \_\_\_\_\_