# 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 dates 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 If yes, 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 properlyperceive, adapt to, or recover from. These stresses may be PHYSICAL, CHEMICAL, or EMOTIONAL in nature.

# PHYSICAL HISTORY

## 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 fights | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Falls on ice | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | Armedservices | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

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 If yes, 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 ☐never Please 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 ☐N/A

## AUTOMOBILE ACCIDENTS:

22. Have you (even as a passenger and 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, mo-ped, 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? ❒Yes ❒No If yes, please explain: _____

25. Do you still have all your body parts? ❒Yes ❒No If no, please explain: _____

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

## 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, or smoke for prolonged periods? ❒Yes ❒No

8. Using the following scale, please grade any dietary selection that is appropriate for you:

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

| | | |
|---|---|---|
| _____Alcohol | _____Eggs | _____Beef |
| _____Coffee | _____Cooked, canned vegetables | _____Poultry |
| _____Tobacco | _____Raw Vegetables | _____Fish |
| _____Artificial Sweeteners | _____Fruit | _____Seafood |
| _____Soda | _____Whole Grains | _____Weight Control Diet |
| _____Diet Food | _____Dairy (milk products) | _____Fasting |
| _____Refined Sugar | _____Fried Foods | _____Organic Foods |

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

# EMOTIONAL HISTORY-

## 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 | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

| | MILD | | MODERATE | | EXTREME | |
|---|---|---|---|---|---|---|
| | P | C | P | C | P | C |
| 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? _____

_____

_____