Hollenbach Family Chiropractic
Creating a Healthy Lifestyle

PERSONAL HEALTH HISTORY

Date: ______________________ Case No: ______________________

Name: ______________________ Email address: ______________________

Address: ______________________ City/State/Zip: ______________________

Date of Birth: ______________________ Social Security #: ______________________

Home Phone No: ______________________ Work Phone No: ______________________

Marital Status: ______________________ Cell Phone No: ______________________

Children's Names and Ages: ______________________

Name of Employer: ______________________ Occupation: ______________________

Hobbies: ______________________

Referred by: ______________________

Name of previous Chiropractor(s): ______________________

When was your last visit? ______________________

How long were you receiving Chiropractic treatment? ______________________

Reason for coming in (chief complaint): ______________________

Are you pregnant? __________If yes, how many weeks: ________ Due Date: ______________ OBGYN / Midwife: ______________

What accidents have you had? (i.e. car, sports, slips/falls) at work or at home (*include dates*):______________________

Were you ever knocked unconscious? ______________________

What fractures or broken bones have you had? (*include dates*): ______________________

____

Surgery: What major surgery have you had? (*include dates*): ______________________

____

What minor surgery have you had? (tonsillectomy, wart/cyst removal, dental extraction) (*include dates*): ______________________

____

Medication:

Present Prescription Medication	Past Prescription Medication	Over-the-counter Medication

Your Birth Record:

Type of Birth: Vaginal ☐ Cesarean ☐ Other: ______________________________

Any complications during your mother's pregnancy or your birth? ______________________________

Any complications after your birth? ______________________________

Current Health

Please use the following to answer questions below: Poor, Good or Excellent

How would you describe your current health? ______________________________

How would you describe your family's health? ______________________________

Describe your: Vision______________________ Hearing ______________________ Coordination ______________________

Do you use the following? Tobacco ☐ Alcohol ☐ Coffee/Tea ☐ Milk ☐

Level of stress in your life: Mild ☐ Moderate ☐ Extreme ☐ 1 2 3 4 5 6 7 8 9 10

Do you purchase any of the following? Bottled water ☐ Vitamins ☐ Health Food ☐

Financial Information

What method of payment will you be using? Insurance ☐ Check ☐ Cash ☐ Credit Card ☐

Who is responsible for this account? ______________________________

Name of Insurance Company: ______________________________ Policy No: ______________________

PLEASE CHECK ANY OF THE FOLLOWING THAT GIVE YOU DIFFICULTY OR YOU HAVE HAD RECENTLY

1	2	3	4
A___ Headaches	A___ Fainting	A___ Shortness of Breath	
B___ Shooting head pain	B___ Loss of balance	B___ Mid-back pain	A___ Numbness-legs/feet
C___ Sinus Trouble	C___ Ringing in ears	C___ Heart Attack	B___ Constipation
D___ Loss of smell	D___ Blurred vision	D___ Low blood pressure	C___ Kidney trouble
E___ Allergies	E___ Lights bother your eyes	E___ High blood pressure	D___ Menstrual cramps/pain
F___ Hay Fever	F___ Neck pain	F___ Anemia	E___ Menstrual irregularity
G___ Asthma	G___ Neck muscle spasm	G___ Stomach trouble	F___ Diabetes
H___ Loss of taste	H___ Grinding in neck	H___ Nervousness	G___ Sleeping problems
I___ Inflammation of throat	I___ Shoulder/arm tightness	I___ Inner tension	H___ Painful joints
J___ Thyroid trouble	J___ Shoulder/arm pain	J___ Irritability	I___ Swollen joints
K___ Facial Twitch	K___ Pins & needles in arms	K___ Gall bladder trouble	J___ Pins & needles in legs
L___ Loss of memory	L___ Pins & needles in hands	L___ Indigestion	K___ Swollen ankles
M___ Fatigue	M___ Cold hands	M___ Intestinal gas	L___ Cold feet
N___ Depression	N___ Numbness – arms/hands	N___ Low back pain	M___ Pain in legs/feet
O___ Dizziness	O___ Swollen tonsils	O___ Hernia	N___ Hip pain
P___ Spinal curvature	P___ Prostate trouble	P___ Stroke	O___ Facial pain
Q___ Chest pain	Q___ Bed wetting	Q___ Arthritis	P___ Jaw pain (TMJ)
R___ Earache	R___ Cancer	R___ Sciatica	Q___ Ulcers

Office use: ______________ ______________ ______________

______________ ______________ ______________ ______________

______________ ______________ ______________ ______________