



Integrative Healing Dynamics

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PERSONAL HISTORY

NAME: _____ **HT:** _____ **WT:** _____

Date of Birth: _____ No. of children: _____

Address: _____

Phone: Work: _____ Home: _____

Referred By: _____ SSN.: _____

Occupation: _____ Spouse Name: _____

In case of emergency please notify: _____

Phone: _____ If minor, name of parents: _____

Please describe your main health concerns for which you came in to this office:

Condition interfering with your ___Work ___Sleep ___Daily routine

Other Doctors seen for these concerns: _____

Diagnosis and recommended treatment: _____

What are your goals for this problem (check all that apply):

___ **pain/symptom relief**

___ **isolate and fix the cause of the problem**

___ **adopting a wellness lifestyle**

Are you willing to make changes to your diet and/or lifestyle? ___ Yes ___ No

How long has it been since you really felt good? _____

Have you received prior chiropractic treatment: _____

Explain: _____

Have you been treated for any health condition by a physician within the past two years:

_____ Explain: _____

___ **Check if you wish to receive our weekly E-Health Tip. Email:** _____

Describe and give dates for the following:

Previous illness: _____

Surgeries: _____

Fractures: _____

Accidents or falls: _____

Latest physical exam and findings: _____

Xrays/C.T./M.R.I. date and findings: _____

Latest chiropractic treatment and Chiropractor's Name: _____

List all medications you now take: _____

List all supplements you now take: _____

Females Only: Date of last period: _____ Pregnant : _____

Birth Control Method: _____

Family history of illness: Mother: _____ Father: _____

Siblings: _____

Spouse: _____

Children: _____

Others: _____

List the conditions you are most interested in correcting:

Signature: _____ Date: _____

I authorize diagnosis and treatment for my minor child: _____

Parents Name: _____ Signature: _____ Date: _____

After 100 years, Chiropractic is still the largest, drugless healing art in the world!

Are your present problems due to an injury? ___ Yes ___ No ___ On the Job ___ Auto Collision ___
Personal Injury ___ Other:

Have you made a report of your accident? ___ Yes ___ No ___ To Employer ___ Auto Carrier ___
Other:

Has the accident been reported? ___ Yes ___ No ___ To Employer ___ Auto Carrier ___ Other:

Please enter “2” (Previously), “3” (Presently), in front of all of the following signs and symptoms. Leave blank if not applicable. A Complete History and Undersatnding of your health will facilitate care.

General

Symptoms

- ___ 784.0 Headache
- ___ 780.6 Fever
- ___ 780.99 Chills
- ___ 780.8 Night Sweats
- ___ 780.2 Fainting
- ___ 780.4 Dizziness
- ___ 780.3 Convulsions
- ___ 780.52 Loss of sleep
- ___ 780.7 Fatigue
- ___ 799.2 Nervousness
- ___ 783 Loss of weight
- ___ 782 Numbness or pain in arms/ legs/ hands
- ___ 995.3 Allergy (What)
- ___
- ___ 786.07 Wheezing
- ___ 729.2 Neuralgia

Muscles & Joints

- ___ 728.9 Weakness
- ___ 781.0 Twitching
- ___ 723.5 Stiff Neck
- ___ 724.5 Backache
- ___ 719.0 Swollen Joints
- ___ 781 Tremors
- ___ 729.5 Foot Trouble
- ___ 724.79 Painful Tail Bone
- ___ 724.5 Pain Between Shoulders
- ___ 737.3 Spinal Curvature

Gastro Intestinal

- ___ 783 Poor appetite
- ___ 536.8 Poor Digestion
- ___ 994.2 Starvation
- ___ 787.3 Belching or Gas
- ___ 787.0 Nausea
- ___ 787.0 Vomiting
- ___ 578.0 Vomiting blood
- ___ 536.8 Pain over stomach
- ___ 564.0 Constipation
- ___ 787.91 Diarrhea
- ___ 562.1 Colon Trouble
- ___ 455.6 Hemorrhoids (Piles)
- ___ 776.7 Fluid Retention
- ___ 873.9 Liver Trouble
- ___ 274 Gout
- ___ 782.4 Jaundice
- ___ 575.9 Gall Bladder Trouble

Cardio-Vascular

- ___ 785.0 Rapid Heart
- ___ 427.89 Slow Heart
- ___ 401.9 High Blood Pressure
- ___ 458.9 Low Blood Pressure
- ___ 786.51 Pain over heart
- ___ 719.07 Swelling Ankles
- ___ 459.9 Poor circulation
- ___ 454.9 Varicose

veins

- ___ 436 Strokes
- ___ 785.1 Palpitations

Eye/Ear/Nose/Throat

- ___ 368.9 Poor Vision
- ___ 378.0 Crossed Eyes
- ___ 379.91 Pain in Eyes
- ___ 389.9 Deafness
- ___ 388.70 Earache
- ___ 388.30 Ear Noises
- ___ 388.60 Ear Discharges
- ___ 478.1 Nasal Obstruction
- ___ 784.7 Nose Bleeds
- ___ 462 Sore Throat
- ___ 784.49 Hoarseness
- ___ 477.9 Hay Fever
- ___ 493.9 Asthma
- ___ 460 Frequent Colds
- ___ 240.9 Enlarged Thyroid
- ___ 463 Tonsillitis
- ___ 473 Sinus Trouble

Skin or Allergies

- ___ 680 Skin Eruption
- ___ 698.9 Itching
- ___ 924.9 Bruising easily
- ___ 701.1 Dryness
- ___ 680.9 Boils
- ___ 782 Sensative Skin
- ___ 708.9 Hives or Allergy
- ___ 692.9 Eczema

Respiratory

- ___ 786.2 Chronic Cough
- ___ 786.3 Spitting Blood
- ___ 786.4 Splitting Phlegm
- ___ 786.50 Chest Pain
- ___ 786.09 Difficulty Breathing

Genito-Urinary

- ___ 788.4 Frequent Urination
- ___ 788.1 Painful Urination
- ___ 599.7 Blood in Urine
- ___ 590 Kidney Infection
- ___ 788.3 Bed Wetting
- ___ 788.3 Inability to control urine
- ___ 601.9 Prostate Trouble

For Women Only

- ___ 625.3 Painful Periods
- ___ 626.2 Excessive Flow
- ___ 626.4 Irregular Cycles
- ___ 627.2 Hot Flashes
- ___ 625.3 Cramps or Backaches
- ___ 623.5 Vaginal Discharge