PERSONAL HISTORY QUESTIONNAIRE

Name: ____ Date: __________

Address: __________________________ City: ________________ State: ____ Zip: __________

Home Phone: ______________ Office Phone: ________________ Cell Phone: ______________

email: __________________________ Occupation: __________________________

Date of Birth: __________ Age: ______ ◇F ◇M Marital Status: ____________ No. of Children: ______

Social Security Number (optional): ____________________ Insurance: ______________

How did you hear about our office? ______________________________________

What is your purpose for consulting our office today? ______________________________

What are your health goals? ______________________________________

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WELLNESS COMMITMENT

At Alice Behr Chiropractic we are dedicated toward achieving the goal of total lasting health for our members. To better help achieve this, we need to understand your commitment toward being healthy. We do *not* ask for a *financial commitment*, but we do ask for your *cooperative commitment*. Based on a scale of 10% to 100%, please **circle** your personal level of commitment toward obtaining and maintaining health and wellness:

10% ········ **20%** ········ **30%** ········ **40%** ········ **50%** ········ **60%** ········ **70%** ········ **80%** ········ **90%** ········ **100%**

Please Answer The Following Questions About Your Personal History:

1. Have you ever had your spine or nervous system examined professionally? ◇Yes ◇No

   If Yes, when? And by whom? ______________________________________

2. Have you received chiropractic spinal adjustments by a Doctor of Chiropractic? ◇Yes ◇No

   If Yes: When was your last visit? ____________ How long were you receiving adjustments? ____________

   How often did you go? ____________ If you stopped, why did you stop going? ____________

3. Please describe what type of adjustments the chiropractor performed, or what technique(s) or methods he or she used? ______________________________________

4. Were you pleased with his or her services? ◇Yes ◇No

5. Does your immediate family receive chiropractic adjustments? ◇Yes ◇No

6. Please circle any of the following modalities towards growth, healing or development that you have used:

   Bodywork/massage   Meditation   Movement/exercise   Prayer   Yoga

   Osteopathy/cranial work   Psychotherapy   Rebirthing/breathwork   Other: ______________

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   ____

7. What do you hope to receive from chiropractic care in this office? ______________________________

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The Practice of chiropractic is based upon the location and adjustment of vertebral subluxations. Subluxations are caused by any stress your body cannot properly perceive, adapt to or recover from. These stresses may be PHYSICAL, CHEMICAL, or EMOTIONAL in nature.

Birth History: If you have information about your birth history, please circle all that apply:

Mother ill prior to her pregnancy with you

Mother had falls, accidents of physical injuries during pregnancy

Mother had a difficult pregnancy with you

Mother took drugs before or during her pregnancy with you

Hospital birth	Home birth	Birthing Center	Traumatic birth	
C section	Breech	Natural	Prolonged	Drug induced
Forceps or suction	Cord around neck	Incubator	Bottle fed	Nursed

Other: ____

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General Physical Trauma:

1. Have you had trauma to your spine? For example: fall on street, ice, in sports, down steps: please describe. Please rate as mild, moderate or severe and give approximate date of trauma:

   ____

   ____

2. Were you ever knocked unconscious? ◇Yes ◇No

   Comments: ____

3. Have you ever used crutches, a walker, or a cane? ◇Yes ◇No

   Comments: ____

4. Have you ever broken any bones? ◇Yes ◇No

   Comments: ____

5. Have you ever had any other impacts, falls, or jolts that you feel specifically may have injured your spine? ◇Yes ◇No

   Comments ____

6. Have you had extensive dental or orthodontial work performed? ◇Yes ◇No

   Comments: ____

7. During the day I (please circle all that apply):

Stand	Drive	Sit	Walk	Do desk work
Do phone work	Do mechanical work	Heavy Lifting		

8. Exercise Habits: How often and what do you do? ____________________

____

9. Were you, or are you active in any particular sport(s)? ◇Yes ◇No

Which: ____________________

10. Have you been hurt in any of these activities? ◇Yes ◇No

Comments: ____________________

11. Have you ever joined a health club? ◇Yes ◇No

12. Do you read for prolonged periods? ◇Yes ◇No

13. Do you play a musical instrument? ◇Yes ◇No

14. Do you wear: ◇Glasses ◇ Bifocals ◇ Contact Lenses

15. Do you have a particular position for watching television? ◇Yes ◇No

Automobile & Other Related Accidents:

Have you (even as a passenger, even if you do not think you were hurt), been involved in a vehicular collision, or near collision? ? ◇Yes ◇No

If Yes, please explain (automobile, bus, bicycle, motorcycle, train, airplane, moped, rollerblades, other): ____________________

____

Medical History:

1. Have you ever been hospitalized? ◇Yes ◇No

   If Yes, what was actually done to you? ____________________

2. Have you had surgery? ◇Yes ◇No

   Comments: ____________________

3. Do you still have all your body parts (Appendix, Tonsils, etc.)? ◇Yes ◇No

   Comments: ____________________

4. Have you ever needed any of the following (circle all that apply):

   Body parts in a cast or immobilized Transfusion Acupuncture

   A spinal tap Spinal injections Physiotherapy Extensive diagnostic x-rays

   Neck collar Corrective Shoes or bars on shoes Spinal brace Traction

   Heel lift X-ray treatments Chemotherapy

5. Do you regularly take vitamins, herbs or homeopathic remedies? ◇Yes ◇No

   If Yes, please list: ____________________

6. Are you now taking any drug (prescription or over-the-counter) regularly? ◇Yes ◇No

7. If Yes, please list drugs, when prescribed and reasons for taking them: ____________________

   ____

8. Are these drugs being prescribed by a physician? ◇Yes ◇No

   If Yes, when was your last visit? ____________________

9. If you were previously taking any medication regularly, please describe: ____________________

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10. Do you or did you work with any chemical, fume, dust, powder, smoke for prolonged periods? ◇Yes ◇No

11. Do you have any other health concerns? ____________________

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Please grade any dietary selection that is appropriate for you using the following scale:

O – Do not consume this
R – Rarely/occasionally consume this
M – Consume this monthly
FM – Consume this a few times a 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 time per day

______ Alcohol
______ Caffeine
______ Tobacco
______ Artificial Sweeteners
______ Soda
______ Diet Food
______ Refined Sugar
______ Bottled/filtered water
______ Raw vegetables
______ Fruit
______ Whole grains
______ Dairy (milk products)
______ Fried foods
______ Red Meat
______ Poultry
______ Eggs
______ Fish
______ Seafood
______ Weight Control Diet
______ Fasting
______ Organic food
______ Cooked Vegetables
______ Canned Vegetables

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

General Trauma

1. Please circle any of the following if you experienced significant stress. Feel free to elaborate:

Childhood stress   School stress   Play, or recreational   Family Stress   Abuse

Personal relationships   Stress of being sick   Work related stress   Stress of commuting

Loss of loved one   Change of lifestyle   Other: ____________________

____

2. Are you happy with the way you look and feel? ◇Yes ◇No

3. When was the last time you felt your best? ____________________

4. How long have you been thinking about pursuing your health? ____________________

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? ____________________

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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? ____________________

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