Network Chiropractic Center Life History Form

The intent of this form is to assist you in your healing process by initiating a thoughtful recognition of your life experiences. Life is a cumulative process; use this form to increase your understanding and appreciation of your own life process and accumulation, both positive and negative.

Date: _____

Name: _____ Address: _____

City: _____ State: _____ Zip: _____

Email Address:_____ Home Phone:_____ Cell Phone: _____

Work Phone: _____ Employer _____ Insurance:_____

Policy Number_____ Group Number_____

Claims Address:_____

Occupation: _____ Employer address: _____

Date of Birth: _____ Age: ____ M ____ F____ Relationship Status: _____

No. of Children: _____ How did you hear about our office? _____

Please answer the following questions about your personal history:

Have you received chiropractic spinal adjustments by a Doctor of Chiropractic? _____

If yes, when was your last visit? _____ For how long were you receiving adjustments? _____

How often did you go? _____ If you stopped, why did you stop? _____

_____

Do you know what type of adjustments the chiropractor performed, or what technique(s) or methods he or she used?

_____

Were you pleased with his or her service? _____

Does anyone in your immediate family receive chiropractic adjustments? _____

Have you had, or do you receive the following vehicles toward health, growth and development? If yes, please list when and any comments you wish to share:

Bodywork/ Massage: _____

Osteopathy/ Cranial Work: _____

Meditation: _____

Psychotherapy: _____

Movement or Exercise: _____

Yoga: _____

Rebirthing/ Breathwork: _____

Prayer: _____

Other: _____

What do you hope to receive from chiropractic spinal adjustments? _____

_____

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

Physical Stress Birth History

1. Was your mother outwardly ill prior to her pregnancy with you? Yes __ No __
2. Did your mother have a difficult pregnancy with you? Yes __ No __
3. Did your mother have any falls, accidents or physical injuries during pregnancy? Yes __ No __
4. Was your delivery traumatic? Yes __ No __
5. Was your delivery: ___drug induced___ forceps or suction __"C" Section __ cord around neck
   __ Breech __ prolonged __ Other_____

6. Was there any other physical or mechanical stress to mother or you as labor progressed, delivery progressed, or as a newborn? Yes __ No __

General Physical Stress

7. Next to the potential cause of vertebral subluxation is provided a space for a check mark. Please write in appropriate space either 'P' for Past or 'C' for Current under the levels of stress: 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	__	__	__	__	__	__	Sports Impacts	__	__	__	__	__	__
Falls down/up steps	__	__	__	__	__	__	Physical Fights	__	__	__	__	__	__
Falls on ice	__	__	__	__	__	__							

Comments:

8. Have you ever been knocked unconscious? Yes __ No __ Date:
   Comments:

9. Have you ever used crutches, a walker, or cane? Comments: Yes __ No __ Date:

10. Have you ever broken any bones? Comments: Yes __ No __ Date:

11. Have you ever had any impacts, falls, jolts that you feel may have injured your spine? Yes ___ No __
    Date: Comments:

12. Have you had extensive dental work done? Yes __ No __ Date:
    Orthodontic work? Yes __ No __ Date:

13. During the day I: sit __ stand __ walk __ desk work __ phone work __ drive __mechanical work __ heavy lifting __

14. I exercise: daily __ weekly __ monthly __

Sports or Leisure

15. Were you, or are you active in any sport(s)? Yes __ No __

Which one(s)? _____

16. Have you been hurt in any of these activities? Yes __ No __ When?
    Comments:

17. Do you read for prolonged periods? Yes __ No __
18. Do you play a musical instrument? Yes __ No __
19. Do you have a particular position for watching television or reading? Yes __ No __
Comments:

20. I wear: glasses __ Bifocals __ contact lenses __

Automobile Accidents

21. Have you, (even as a passenger, even if you do not think you were hurt), been involved in a vehicular collision /near collision? Please list approximate dates and severity (Mild, Moderate or Extreme)?
Automobile: _____
_____
Bus, bicycle, motorcycle, train, airplane, moped, or other vehicles: _____
_____
_____

Medical Treatment

22. Have you ever been hospitalized?
If yes what was actually done to you? _____
_____
Have you had surgery? _____
Do you still have all your body parts? _____
Have you had: ___a spinal tap __ spinal injections __ physiotherapy __ neck collar __ spinal brace __ traction ___heel lift __ X-ray treatments __ corrective bars/shoes __ extensive diagnostic X-rays __ acupuncture ___chemotherapy __ transfusion __ bone in a cast or immobilized

Chemical Stress Birth History

23. Was your mother regularly taking any drug prior to or during her pregnancy with you? Alcohol __ Smoking __
24. Was her labor chemically induced or altered? Yes __ No __
25. Was your mother: conscious __ semiconscious __ unconscious __ during your delivery?
26. Any other chemical stress that your mother may have been subject to: _____
_____

General Chemical Stress

27. Are you now taking any drug (prescription or over-the-counter) regularly? Please list:
Drug: _____ Reason: _____
Drug: _____ Reason: _____
Drug: _____ Reason: _____
Are these drugs being prescribed by a physician? _____ Last visit: _____

28. Were you previously taking any medication regularly? _____
_____

29. Do you work with any chemical, fume, dust, powder, or smoke for prolonged periods? Yes___ No___
Comments:

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

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

___Alcohol
___Coffee
___Tobacco
___Artificial Sweeteners
___Soda
___Diet Food
___Refined Sugar

___Eggs
___Cooked, Canned Vegetables
___Raw Vegetables
___Fruit
___Whole Grains
___Dairy (Milk Products)
___Fried Foods

___Beef
___Poultry
___Fish
___Seafood
___Weight Control Diet
___Fasting
___Organic Foods

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

The kind **Emotional / Mental Stress Birth History**

31. My birth was: at home __ in a birthing center __ in a hospital __

32. Were you incubated or isolated after birth? _____

33. Were you: bottle fed formula __ bottle fed mother's milk __ nursed __ nursed and bottle fed __

General Emotional / Mental Stress

With each of the following spinal stress situations and potential cause of vertebral subluxations, please check either "P" for Past or "C" for Current or both as they apply ..

	MILD P	MILD C	MODERATE P	MODERATE C	EXTREME P	EXTREME C
Childhood Stress	☐	☐	☐	☐	☐	☐
School Stress	☐	☐	☐	☐	☐	☐
Play or Recreational	☐	☐	☐	☐	☐	☐
Family Stress	☐	☐	☐	☐	☐	☐
Personal Relationships	☐	☐	☐	☐	☐	☐
Stress of being sick	☐	☐	☐	☐	☐	☐

	MILD P	MILD C	MODERATE P	MODERATE C	EXTREME P	EXTREME C
Work Related Stress	☐	☐	☐	☐	☐	☐
Stress of Commuting	☐	☐	☐	☐	☐	☐
Loss of loved one	☐	☐	☐	☐	☐	☐
Change in lifestyle	☐	☐	☐	☐	☐	☐
Change in vocation	☐	☐	☐	☐	☐	☐
Abuse	☐	☐	☐	☐	☐	☐

34. How do you grade your physical health? Excellent __ Good __ Fair __ Poor __ Getting Better __ Getting Worse __

35. How do you grade your emotional-mental health? Excellent __ Good __ Fair __ Poor __ Getting Better __ Getting Worse __

36. If you consider yourself ill, why do you feel you are ill? _____

_____

37. If you consider yourself well, why do you feel you are well? _____

_____

38. 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? _____

_____

_____