

# “Health History- Application for Care”

This is a time for you to share with us, where you are regarding your health and life.

Use Blue or Black Ink ONLY

Mr/Mrs/Ms/Miss/Dr/Rev LAST NAME: \_\_\_\_\_ FIRST: \_\_\_\_\_ (MI) \_\_\_\_\_  
STREET ADDRESS: \_\_\_\_\_  
CITY, STATE, ZIP: \_\_\_\_\_  
PRIMARY PHONE #: \_\_\_\_\_ MOBILE #: \_\_\_\_\_  
E-MAIL ADDRESS: \_\_\_\_\_ WORK E-MAIL ADDRESS \_\_\_\_\_  
CONTACT METHOD (CHECK ONE):  PRIMARY PHONE  MOBILE PHONE  HOME EMAIL  WORK EMAIL  
BIRTH-DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_ AGE: \_\_\_\_\_ SS # \_\_\_\_\_  
MARITAL STATUS: Married – Single – Separated – Divorced - Widow SPOUSE’S NAME: \_\_\_\_\_  
CHILDREN: ( ) YES ( ) NO HOW MANY AT HOME? \_\_\_\_\_  
NAME: \_\_\_\_\_ AGE: \_\_\_\_\_ NAME \_\_\_\_\_ AGE: \_\_\_\_\_  
NAME: \_\_\_\_\_ AGE: \_\_\_\_\_ NAME \_\_\_\_\_ AGE: \_\_\_\_\_  
CURRENT OCCUPATION: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_  
EMPLOYMENT INFO: ( ) FULL TIME ( ) PART-TIME ( ) SELF-EMPLOYED ( ) RETIRED ( ) DISABLED ( ) NOT EMPLOYED  
WORK #: \_\_\_\_\_ EXTENSION: \_\_\_\_\_  
EMPLOYMENT MAILING ADDRESS: \_\_\_\_\_  
PAST OCCUPATION(S): \_\_\_\_\_  
In case of emergency, whom should we contact? Name: \_\_\_\_\_  
Relationship to you: \_\_\_\_\_ Phone #(s): \_\_\_\_\_/\_\_\_\_\_

Research shows that your spine should be checked regularly. How many times have you visited a chiropractor in your lifetime? Approx. \_\_\_\_\_ times ( ) Never Been Date of last chiropractic adjustment? \_\_\_\_\_  
Previous Chiropractor(s) Name: \_\_\_\_\_; \_\_\_\_\_  
Were you pleased with your chiropractic care? Yes No Comments: \_\_\_\_\_

When was your last complete spinal examination including x-rays? \_\_\_\_\_ Where? \_\_\_\_\_

Have you ever been told that you have a spinal curvature, spinal arthritis, or inherited spinal problem?  
( ) Yes or ( ) No **If yes, please circle the appropriate one from the list.**

Spinal misalignments cause decay and degeneration which results in grinding or cracking. Do you ever hear noises when you move your neck, back, or other body part? ( ) Yes ( ) No **IF YES INDICATE WHERE BELOW**

Spinal misalignments can make you feel like you need to twist, stretch or crack your neck or back.  
Do you ever feel the need to crack or pop your neck or lower spine? ( ) Yes ( ) No **IF YES INDICATE WHERE BELOW**

Auto and work-related injuries can cause serious spinal problems. Is this visit related to an auto injury or work related injury? ( ) Yes ( ) No **Please circle above the appropriate one.**

Spinal health is especially important during pregnancy. Is there **any chance** that you are pregnant or breast-feeding? ( ) Yes ( ) No **Approx. Due Date:** \_\_\_\_\_ Research states 6-12 months of breast-feeding is critical for developing child. **How long have you been breast feeding your child?** \_\_\_\_\_

**\*There are many reasons why people seek chiropractic care and sometimes it’s due to a pain or other type of symptoms. Our focus is on helping you regain the EASE you have lost. The next-page allows you the opportunity to share why you are consulting our office. It is very important to fill-out each question that follows completely.**

State #1 reason you are consulting our office: \_\_\_\_\_

**Pain/Discomfort Level:** No Pain 1 2 3 4 5 6 7 8 9 10 Worst Pain

**How did this problem occur?** (Examples: trauma/fall/sports injury/auto accident/work related injury/raking/heavy lifting/house work/extra driving, etc.)

**When did this problem begin?** (Give as close to exact date as possible)

**The frequency of this problem? (Circle)** 0 10 20 30 40 50 60 70 80 90 100 (%) of your *Day or Week*

**Is this problem worse in the** *Morning / by Midday / at the end of the day / at night / Sleep time / anytime*

**Does this problem radiate/move elsewhere?** Y N If Yes, where? \_\_\_\_\_

**Quality/feel of the problem? (Circle)** Dull - Sharp - Throbbing - Burning - Deep - Aching  
Tingling - Stabbing - Cramping - Numbness - Radiating  
Sore - Tense - Other \_\_\_\_\_

**Aggravating Factors: (Circle)**

Sitting - Standing - Walking - Bending - Stooping - Lifting  
Sleeping - Sneezing - Coughing - Straining - Reaching - Twisting  
Looking up - Looking down - Movement - Rest - Lying on back - Driving  
Computer use - Scooping - House chores - Exercise - Lying on your stomach  
Stair stepping - Other \_\_\_\_\_

**Relieving Factors: (Circle)**

Sitting - Standing - Lying down - Keeping knees bent - Support of any kind - No movement  
Movement - Heat pack - Warm/hot shower - Ice pack - Analgesic topical cream  
Ibuprofen - Other Medication \_\_\_\_\_ - Rest - Stretching/Exercise - Adjustments  
Other \_\_\_\_\_

State #2 reason you are consulting our office: \_\_\_\_\_

**Pain/Discomfort Level:** No Pain 1 2 3 4 5 6 7 8 9 10 Worst Pain

**How did this problem occur?** (Examples: trauma/fall/sports injury/auto accident/work related injury/raking/heavy lifting/house work/extra driving, etc.)

**When did this problem begin?** (Give as close to exact date as possible)

**The frequency of this problem? (Circle)** 0 10 20 30 40 50 60 70 80 90 100 (%) of your *Day or Week*

**Is this problem worse in the** *Morning / by Midday / at the end of the day / at night / Sleep time / anytime*

**Does this problem radiate/move elsewhere?** Y N If Yes, where? \_\_\_\_\_

**Quality/feel of the problem? (Circle)** Dull - Sharp - Throbbing - Burning - Deep - Aching  
Tingling - Stabbing - Cramping - Numbness - Radiating  
Sore - Tense - Other \_\_\_\_\_

**Aggravating Factors: (Circle)**

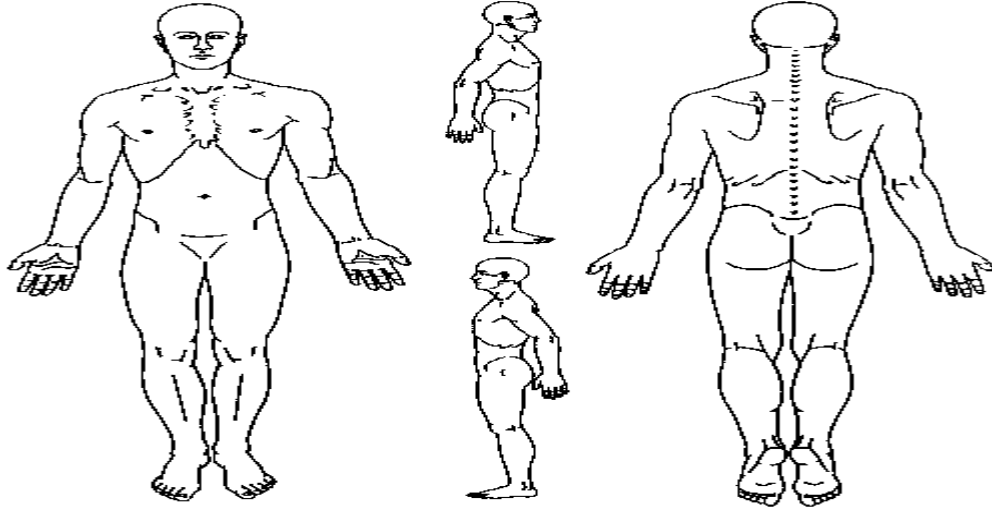
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**Relieving Factors: (Circle)**

Sitting - Standing - Lying down - Keeping knees bent - Support of any kind - No movement  
Movement - Heat pack - Warm/hot shower - Ice pack - Analgesic topical cream  
Ibuprofen - Other Medication \_\_\_\_\_ - Rest - Stretching/Exercise - Adjustments - Nothing  
Other \_\_\_\_\_

Please mark on these BODY DIAGRAMS, where your Problems/Complaints are directly. Use symbols below for more detail.

**A** =ACHE **B** =BURNING **N** =NUMBNESS **P** =PINS & NEEDLES **S** =STABBING **X** =Pain



Additional Health History

We want to thank you in advance with regards to filling out the following information. I feel I can better help you by learning about the following. -Dr. Humiston

Any known allergies? Y N (List below and when they started)

To what? \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Family History (mother-father-brother-sister-grandparents)

**Family Member** \_\_\_\_\_ **Health Condition** \_\_\_\_\_ **Alive/Deceased**

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List previous Surgeries with dates and where performed?

◊ N/A

List previous Illnesses with dates?

◊ N/A

List previous Hospitalizations with dates?

◊ N/A

Any Blood work in last 12 months? Yes No Date (approx.): \_\_\_\_\_

Where was it performed? \_\_\_\_\_

Significant Findings/Results (i.e. High cholesterol; High triglycerides; High glucose)?

	<u>Current Medications</u>	<u>For What Condition</u>	<u>Strength</u>	<u>Qty. Per Day</u>	<u>Prescribed by</u>	<u>How long taken</u>
1.	_____	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____	_____
5.	_____	_____	_____	_____	_____	_____

Name of Medical Doctor/Health Provider: \_\_\_\_\_  Do not have a physician  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

\*If necessary, can we send records to your physician regarding your physical exam, x-ray and possible care findings? **Y N**

**Have you ever have/had any of the following diseases or conditions?**

**You must Circle "C" for currently have, "P" had in the past, or "N" for never next to each checked area below.**

<b>P N</b>	<b>Stroke</b>	<b>C P N</b>	<b>Cancer</b>
<b>P N</b>	<b>Heart Attack</b>	<b>C P N</b>	<b>Chemo/Radiation</b>
<b>C P N</b>	<b>Pacemaker Implant</b>	<b>C P N</b>	<b>Seizures</b>
<b>C P N</b>	<b>Carotid Artery Disease</b>	<b>C P N</b>	<b>Uncontrolled bowel/bladder</b>
<b>C P N</b>	<b>Balance Problems</b>	<b>C P N</b>	<b>Unusual speech or eye dysfunction (circle)</b>
<b>C P N</b>	<b>Intense 'Unusual' Headaches</b>	<b>C P N</b>	<b>Trouble Swallowing</b>

❖ Payment method for non-insurance covered part of services rendered: ( ) Cash ( ) Debit ( ) Charge ( ) Check

■ I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.  
 X \_\_\_\_\_  
**Patient Signature** **Date**

**If you are requesting that we file your insurance, please read and sign the following.**

**IT IS USUAL AND CUSTOMARY TO PAY FOR SERVICES AS RENDERED UNLESS OTHERWISE ARRANGED.**

I do hereby authorize Humiston Family Chiropractic (Dr. Richard S. Humiston) to furnish my insurance co. with a full report of physical examination, diagnosis, treatment, prognosis, etc. of myself in regard to my condition(s), if requested by them.

I hereby authorize and direct payment directly to said doctor such sums as may be due on owing him for chiropractic service rendered to me. I understand I am directly and fully responsible to said doctor for all medical bills submitted by him for service rendered to me.

This agreement is made solely for said doctor's additional protection and consideration of his awaiting payment.

I have read and agree to be bound by the terms of this *assignment of benefits*. I have also been advised that if my insurance company does not cooperate in protecting said doctor's interest, he will not await payment but may declare the entire balance due and payable; these assigned proceeds shall not exceed amounts due and payable to the said doctor for ONLY services rendered.

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Name: \_\_\_\_\_ Date \_\_\_\_\_

**Wellness Index:** The following information will further enhance our ability to serve you and help maximize the health you deserve to have. Remember health is a process and as long as you are moving towards greater levels of it, it does not matter where you are right now.

	<u>Supplements</u>	<u>Brand</u>	<u>Qty Per Day</u>
1.	_____ / _____	_____ / _____	_____ / _____
2.	_____ / _____	_____ / _____	_____ / _____
3.	_____ / _____	_____ / _____	_____ / _____

Are you interested in learning about how WHOLE FOOD supplements vitamins/minerals/herbs can help support your health versus SYNTHETIC Brands? Yes NO

Occupational History

Describe your work activities below / Physical level (Low \* Medium \* High)

(Note-If you are currently not working share a past job you have had and answer accordingly)

\_\_\_\_\_

\_\_\_\_\_

Were you ever injured on the job? Y N

How? \_\_\_\_\_

When? \_\_\_\_\_

Recreational/Exercise

<u>Activity(s)</u>	<u>Frequency (Days/week)</u>	<u>Current Level of Difficulty</u> (No Difficulty 0-10 most difficult)
_____	_____	_____
_____	_____	_____
_____	_____	_____

Height: \_\_\_\_\_' \_\_\_\_\_"

Weight: \_\_\_\_\_ lbs.

Goal weight within 6 months \_\_\_\_\_ 1 year \_\_\_\_\_  Presently '*not a concern*'

Do You Smoke? Yes No Occasionally Years Smoked: \_\_\_\_\_ Packs Per Day \_\_\_\_\_

Level of interest in Quitting: Low - 0-1-2-3-4-5-6-7-8-9-10 – High

Daily Alcohol Consumption: \_\_\_\_\_

Daily Coffee Consumption: \_\_\_\_\_ (Est. ounces) \_\_\_\_\_ Cups (Circle) De-Caf / Caffeinated

Daily Soda Consumption: \_\_\_\_\_ (Est. ounces) Brand: \_\_\_\_\_

Pure Water Consumption: \_\_\_\_\_ (Est. ounces) Type Mainly Consumed: City Well Filtered Spring

Pain Reliever(s): Type: \_\_\_\_\_; Quantity: \_\_\_\_\_ /day-week; How long: \_\_\_\_\_

Healthy Eating Rank (Think Fruits and Veggies): Terrible – 0 1 2 3 4 5 6 7 8 9 10 – Excellent

Sleep Amount on Avg. Per Night: \_\_\_\_\_ hrs.

Quality of Sleep on Avg.: **Poor Fair Good Excellent**

If your sleep quality is less than “Good”, state why?

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Poor posture leads to poor health and often indicates a spinal problem. How would you rate your posture?

**Poor - 1 2 3 4 5 6 7 8 9 10 – Excellent**

Stress can cause or accelerate spinal damage. How would you rate your level of general stress within the last 90 days?

**Low - 1 2 3 4 5 6 7 8 9 10 - High**

Currently my physical health is (circle one) - **Excellent 0-1-2-3-4-5-6-7-8-9-10 Poor**

Currently my emotional health is (circle one) - **Excellent 0-1-2-3-4-5-6-7-8-9-10 Poor**

Major Stressors: \_\_\_\_\_

Things to improve: \_\_\_\_\_

Other health goals: \_\_\_\_\_

How committed are you to *actively* participating in moving yourself toward greater levels of health, peace and wellness? (Circle your answer) ***Not at all - 1 2 3 4 5 6 7 8 9 10 - 100% committed***

**Other comments:**

**Sign:** \_\_\_\_\_