PERSONAL RECORD

NAME:_____ Today's Date: _____

ADDRESS:_____ Date of Birth: _____Age: _____

CITY:_____ST____ZIP_____ Home Phone: _____

CIRCLE: **M**arried **W**idowed **S**ingle **D**ivorced Cell Phone: _____

Spouse's Name: _____ Work Phone: _____

Occupation: _____

E-mail address:_____ Referred By: _____

Please use page 4 if more space is needed

1. When you were born, was it a difficult birth? **Y N** Very rapid birth? **Y N** C-section? **Y N** Forceps? **Y N**
   Comments:

2. Have you ever had blows to the head? (Need not have caused unconsciousness. Examples: Fall from a bicycle or down stairs, car or sports accident, object hitting head, etc.) **Y N** If yes, please list age(s) or year(s) and describe what happened. Describe any problems experienced afterward.

3. Have you ever experienced a "whiplash"? **Y N** If yes, please say what happened and what you experienced afterward.

4. Have you ever had any fractures, sprains, or other sports or auto injuries? **Y N** If so, please list with approximate date(s) or age(s).

5. Surgeries? **Y N** Please list, with approximate date(s) or age(s).

6. Exercise/Physical Activity Pattern (walking/weights/aerobics/frequency)

7. Have you ever experienced chiropractic manipulation? **Y N**
   Was it for: Neck Upper or Mid back Low back Other ?
   Are you currently receiving adjustments? **Y N**

8. Are you taking any medication? **Y N** Under doctor's care for any reason? **Y N** If so, please list/explain:

9. What is your Blood Type? _____ Have you ever had any transfusions? **Y N** When? _____

10. Are you receiving any other kinds of healing modalities? **Y N** Please list:

11. Family Health History (parents/siblings/grandparents)

12. Describe your diet. *(Check the one(s) that most aptly describes your eating pattern, and elaborate in the space provided.)*

- o heavy meat (all kinds). . . .
- o some vegetarian (eat chicken or fish). . . .
- o vegetarian (no meat). . . .
- o vegan (no eggs or milk products). . . .

- o _____% red meat
- o _____% chicken or fish
- o _____% vegetables
- o _____% fruits
- o _____% grains
- o _____% other*(describe)*_____
- o **100 %**

Describe your diet in the space below.

13. Are you taking *(Please indicate which ones and, if possible, which brands)*

- o vitamins / minerals. . . .
- o phytochemicals / carotinoids. . . .
- o antioxidants. . . .
- o enzymes. . . .
- o homeopathic remedies. . . .
- o herbs. . . .
- o other. . . .

14. Do you use any of the following: *(Please indicate amounts and frequency)*

- o alcohol. . . .
- o coffee. . . .
- o tobacco. . . .
- o sugar. . . .
- o recreational drugs. . . .

15. Do you have, or have you ever had: *(Please check all that apply)*

o measles	o bronchitis	o hepatitis	o pacemaker
o mumps	o rheumatic fever	o HIV or AIDS	o cancer
o chicken pox	o pneumonia	o herpes	o vaccinations
o scarlet fever	o asthma	o heart attack	o other

16. Do you have any allergies? **Y N**
types: food **Y N** airborne **Y N** environmental **Y N**

Do you have any respiratory / sinus problems? **Y N** skin irritations **Y N** other **Y N**

Do any other members of your family have any allergies? **Y N**

17. Number of pregnancies _____ Number of children _____ Type of contraception *(if applicable)*: _____

18. Do you experience any of the following? If so, please indicate with: **F = Frequent, S = Sometimes**

___ headaches
___ stiff neck
___ upper back pain
___ lower back pain
___ sciatica (pain down leg)
___ knee pain
___ foot / ankle pain
___ elbow pain
___ hip pain
___ fatigue
___ anxiety
___ attention deficit problems
___ "learning difficulties"
___ rapid heartbeat
___ very low blood pressure
___ tachycardia
___ cysts
___ difficulty urinating
___ kidney stones
___ constipation
___ coordination problems
___ dental caries (cavities)
___ feeling "on edge"
___ craving of sugar
___ seizures
___ diarrhea
___ light-headedness
___ eye pain / dryness
___ ringing of ears / earache
___ diminished sense of smell
___ diminished sense of taste
___ equilibrium problems
___ TGIF
___ wrist / hand pain
___ sinus congestion
___ diminshed immune response
___ panic attacks
___ trouble thinking / focusing
___ hungry right after eating
___ trouble taking deep breath
___ high cholesterol (LDL)
___ anemia
___ arthritis (joint inflammation)
___ frequency of urination
___ gall stones
___ depression
___ psoriasis
___ dental abscess
___ feeling of "impending doom"
___ parasites known / suspected
___ swollen glands
___ trouble sleeping
___ heartburn
___ intestinal gas
___ intestinal pain
___ difficulty swallowing
___ tickling in throat
___ pain in/behind sternum or ribs
___ shoulder pain
___ TMJ (jaw) problems
___ frequent colds / flu
___ feeling of "weakness"
___ hyper-activity
___ "fuzzy"-headedness
___ stomach feels too full to eat
___ high blood pressure
___ high triglycerides
___ osteoporosis
___ tumors
___ burning with urination
___ tired of questionnaires
___ accident-prone
___ acne
___ periodontitis
___ heel pain
___ numbness / tingling in fingers
___ other:_____

CURRENT CONCERNS

If you have specific problems or concerns, please list. Indicate when and how the problem started, diagnosis and treatment, if any. Did it help, or is it helping?

If you have no particular pain or problems, but are interested in improved energy and sense of well-being, enhanced immune response, and/or early detection/prevention of problems, please indicate that! (Note: no promises are made for QE)

THANK YOU !

To the best of my knowledge, I have listed all of my past and current conditions.

signature_____ ***date***_____