

TOTAL HEALTH CHIROPRACTIC, PC

Richard Puchta D.C.

Personal and Family Health History

Date _____
 Name _____
 If minor, names of parents/guardians: _____

 Address _____
 City _____ State _____ Zip _____
 Phone: (H) _____ (W) _____
 Cell phone: _____ Email: _____
 Date of Birth _____ (Age _____)
 Referred By _____
 Have you looked at our website? Y N

Social Security # _____
 Occupation _____
 Medicare? Y N Medicare #: _____
 Medicare alternative? Y N
 Name of medicare supplemental insurance: _____

 Employer _____
 Marital Status S M D W
 Spouse's Name _____
 Spouse's Occupation _____
 Have you been treated by a chiropractor before? Y N
 If so, whom: _____

You deserve to be healthy. Life is a miracle and so are you. When you were created, you were given all the blue-prints, intelligence, tools, and systems to live an active healthy life. Unfortunately, your health can be interfered with through accidents and challenges that cause a disruption to your health expression. Through your examination and through your involvement in chiropractic care, we will work to remove these interferences to your natural health expression so that you can live the quality of life you deserve.

Chiropractor's Comments

Circle all that Apply

1. Was Your Birth Traumatic?

Long Delivery?	Y	_____
Difficult Delivery?	Y	_____
Forceps?.....	Y	_____
Caesarian?	Y	_____
Breach/cephalic?	Y	_____
Home birth?.....	Y	_____
Mother given drugs during delivery	Y	_____
Induced Labor?	Y	_____

2. Growth and Development (during your childhood)

Did you ever once...

Learn to care for your spine?	Y	_____
Fall out of bed?	Y	_____
Bang your head?.....	Y	_____
Breastfeed?	Y	_____
Childhood sickness?	Y	_____
Have any Accidents?.....	Y	_____
Have Surgery?	Y	_____
Take Drugs?	Y	_____
Fall while learning to walk?.....	Y	_____
Bullied by your siblings?	Y	_____
Child Abuse?	Y	_____
Emotional Traumas?.....	Y	_____
Chair pulled out when sitting?	Y	_____
Fall down the stairs?	Y	_____
Pulled by your arm?.....	Y	_____
Experience other traumas?	Y	_____

3. Current Health Habits

Did/do you...

Smoke?	Y	_____
Drink	Y	_____
Diet (do you eat healthy foods?)	Y	_____

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A Family Health and Wellness Center

Richard Puchta D.C.

Have you been in accidents? Y _____
Have you had surgery? Y _____
Were organs replaced/removed?.....Y..... _____
Drugs? (Prescriptive or Non-Prescriptive) Y _____
Have Teeth Problems? Y _____
Have Eye Problems?.....Y..... _____
Have Hearing Problems? Y _____
Exercise regularly? Y _____
Have sleeping problems? Y _____
Have occupational stress?.....Y..... _____
Have physical stress? Y _____
Have mental stress? Y _____
Have hobbies/sports injuries? Y _____
Sleeping posture – side–stomach–back _____

Current Health Condition

Present Complaint (be brief) Reason For Your Visit Today

Major _____

Pain or Problem started on _____

Pains are: Sharp Dull Constant Intermittent

What activities aggravate your condition/pain? _____

What activities lessen your condition/pain? _____

Is condition worse during certain times of the day? _____

Is this condition interfering with work? _____ Sleep? _____ Routine? _____ Other? _____

Is this condition getting progressively worse? _____

Other Doctors seen for this condition _____

Any home remedies? _____

Other symptoms:

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Face Flushed | <input type="checkbox"/> Light Bothers Eyes | <input type="checkbox"/> Feet Cold |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Neck Stiff | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Hands Cold |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Pins & Needles in Legs | <input type="checkbox"/> Ears Ring | <input type="checkbox"/> Stomach Upset |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Pins & Needles in Arms | <input type="checkbox"/> Fever | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Numbness in Fingers | <input type="checkbox"/> Fainting | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Numbness in Toes | <input type="checkbox"/> Cold Sweats | <input type="checkbox"/> Buzzing in Ear |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Loss of Smell | |
| <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Loss of Taste | |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Depression | <input type="checkbox"/> Diarrhea | |

Have you been under drug and medical care? _____

What medications are you taking? _____

How Long? _____ What surgeries have you had? _____ When? _____

What side effects have you experienced from the drugs and surgery? _____

Is there a family history of:

	Heart Disease	Arthritis	Cancer	Diabetes	Other _____
Father's Side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mother's Side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Upon the completion of your first visit, you will receive a Chiropractic Report to discuss the different types of Active Life Plans that are available to you. Chiropractic Active Life Plans are designed to help get you feeling better quickly and to help you and your family be as healthy as possible. Please review the explanations of the Chiropractic Active Life Plans prior to your Chiropractic Report appointment so you can choose the level of participation that supports you in reaching all your health goals.

As a result of my chiropractic care, I would like to:

Please check all that apply

- | | |
|---|---|
| <input type="checkbox"/> Feel better quickly | <input type="checkbox"/> Have a healthier body by keeping my nerve system healthy |
| <input type="checkbox"/> Have a healthier spine | <input type="checkbox"/> Live a healthier lifestyle |

(Patient or Parent/Guardian signature)

(Date)