

Family Health History

Name: _____ Date: _____ Referred By: _____
 Date of Birth: _____ Age: _____ Occupation: _____
 Marital Status: Single Married (Anniversary Date) Divorce Widow
 Spouse's Name: _____ Spouse's Occupation: _____

Number of Children and Ages

Previous Chiropractic Care?

Name: _____	DOB _____	Yes _____	No _____	Reason _____
Name: _____	DOB _____	Yes _____	No _____	Reason _____
Name: _____	DOB _____	Yes _____	No _____	Reason _____
Name: _____	DOB _____	Yes _____	No _____	Reason _____

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.

(Check any of the symptoms that your family has had)

- | | | | |
|---|---|---|--|
| <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 problem | <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"/> Buzzing in Ear |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Numbness in Toes | <input type="checkbox"/> Cold Sweats | <input type="checkbox"/> Loss of Balance |
| <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 | |

Do you have family history of:

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