Appalachian Family Chiropractic

Health History

Name: _____ Age: _____ Date of Birth: _____ Gender: F/M

Address: _____ City: _____ State: _____ Zip: _____

Phone: (H)_____ (W)_____ (Cell) _____

Occupation: _____ Email: _____

Family Status: (Circle One) Single/Divorced/Married/Widow(er)/Significant Other # of Children: _____

Emergency Contact: _____ Phone #: _____

How did you hear about Appalachian Family Chiropractic? _____

About Spouse or Parent: Name: _____ Employer: _____

Occupation: _____ Phone #: _____ Work/Cell #: _____

Your Chiropractic Experience:

Have you been to a Chiropractor before? Yes ____ No ____ Reason for those visits? _____

Doctor's Name: _____ Approximate Date of Last Visit: _____

Has any adult in your family seen a Chiropractor? Yes ____ No ___

Has any child in your family seen a Chiropractor? Yes ____ No ___

Were you aware that...

...Doctors of Chiropractic work with the Nervous System? Yes ___ No ___

...the nervous system controls all bodily functions and systems? Yes ___ No ___

...Chiropractic is the largest natural healing profession in the world? Yes ___ No ___

...if Chiropractic care starts at birth, you can achieve a higher level of health throughout life? Yes ___ No ___

Chief Complaint:

Please list your major problems and/or symptoms and the approximate date it began. Please rank in order of importance to you.. When problem began:

1. _____ _____

2. _____ _____

3. _____ _____

4. _____ _____

5. _____ _____

Have you seen other doctors for this condition? Yes ____ No _____ Doctor's Name(s) _____

Type of Treatment _____ Results _____

Has this condition occurred before? Yes ____ No _____ Explain _____

Does this condition interfere with Work _____ Sleep _____ Daily Routine _____ Other _____