Life History Form

The intend of this form is to assist you in your healing process by initiating a thoughtful recognition of your life experiences. Life is a cumulative process; use this form to increase your understanding and appreciation of your own life process and accumulation, both positive and negative.

Date: _____

Name: _____ Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Employer _____

Occupation:_____ Employer address: _____

Date of Birth: _____ Age: _____ M ____ F _____ Relationship Status: _____

No. of Children: _____ How did you hear about our office? _____

Please answer the following questions about your personal history:

Have you received chiropractic spinal adjustments by a Doctor of Chiropractic? _____

If Yes, when was your last visit? _____ For how long were you receiving adjustments? _____

How often did you go? _____ If you stopped, why did you stop? _____

_____

Do you know what type of adjustments the chiropractor performed, or what technique(s) or methods he or she used?

_____

Were you pleased with his or her service? _____

Does anyone in your immediate family receive chiropractic adjustments? _____

Have you had, or do you receive the following vehicles toward health, growth and development?

If yes, please list when and any comments you wish to share:

Bodywork/ Massage: _____

Osteopathy/ Cranial Work: _____

Meditation: _____

Psychotherapy: _____

Movement or Exercise: _____

Yoga: _____

Rebirthing/ Breathwork: _____

Prayer: _____

Other: _____

What do you hope to receive from chiropractic spinal adjustments? _____

_____

_____

The practice of chiropractic is based upon the location and adjustment of vertebral subluxations. These spinal subluxations are caused by any stress your body can not properly perceive, adapt to or recover from. These stresses may be PHYSICAL, CHEMICAL, or EMOTIONAL / MENTAL in nature.

Physical Stress Birth History

1. Was your mother outwardly ill prior to her pregnancy with you? Yes ə No ə
2. Did your mother have a difficult pregnancy with you? Yes ə No ə
3. Did your mother have any falls, accidents or physical injuries during pregnancy? Yes ə No ə
4. Was your delivery traumatic? Yes ə No ə
5. Was your delivery:

drug induced	ə	forceps or suction	ə
"C" Section	ə	cord around neck	ə
Breech	ə	prolonged	ə

Other _____

6. Was there any other physical or mechanical stress to mother or you as labor progressed, delivery progressed, or as a newborn? Yes ə No ə

General Physical Stress

7. Next to the potential cause of vertebral subluxation is provided a space for a check mark. Please write in appropriate space either 'P' for Past or 'C' for Current under the levels of stress: Mild, Moderate, or Extreme.

	MILD		MODERATE		EXTREME			MILD		MODERATE		EXTREME	
	P	C	P	C	P	C		P	C	P	C	P	C
Falls from crib	ə	ə	ə	ə	ə	ə	Sports Impacts	ə	ə	ə	ə	ə	ə
Falls down/up steps	ə	ə	ə	ə	ə	ə	Physical Fights	ə	ə	ə	ə	ə	ə
Falls on ice	ə	ə	ə	ə	ə	ə							

Comments: _____

8. Have you ever been knocked unconscious? Yes ə No ə Date: _____
   Comments: _____
9. Have you ever used crutches, a walker, or cane? Yes ə No ə Date: _____
   Comments: _____
10. Have you ever broken any bones? Yes ə No ə Date: _____
    Comments: _____
11. Have you ever had any impacts, falls, jolts that you feel may have injured your spine? Yes ə No ə
    Date: _____
    Comments: _____
12. Have you had extensive dental work done? Yes ə No ə Date: _____
    Orthodontal work? Yes ə No ə Date: _____
13. During the day I: sit ə stand ə walk ə desk work ə phone work ə drive ə
    mechanical work ə heavy lifting ə
14. I exercise: daily ə weekly ə monthly ə

Sports or Leisure

15. Were you, or are you active in any sport(s)? Yes ə No ə
    Which one(s)? _____
16. Have you been hurt in any of these activities? Yes ə No ə When? _____
    Comments: _____

17. Do you read for prolonged periods? Yes ə No ə
18. Do you play a musical instrument? Yes ə No ə
19. Do you have a particular position for watching television or reading? Yes ə No ə

Comments: _____

_____

20. I wear: glasses ə Bifocals ə contact lenses ə

Automobile Accidents

21. Have you, (even as a passenger, even if you do not think you were hurt), been involved in a vehicular collision / near collision? Please list approximate dates and severity (Mild. Moderate, or Extreme)?

Automobile: _____

_____

_____

Bus, bicycle, motorcycle, train, airplane, moped, or other vehicles: _____

_____

_____

Medical Treatment

22. Have you ever been hospitalized?

If yes what was actually done to you? _____

_____

Have you had surgery? _____

Do you still have all your body parts? _____

Have you had: a spinal tap ə spinal injections ə physiotherapy ə neck collar ə spinal brace ə traction ə heel lift ə X-ray treatments ə corrective bars/shoes ə extensive diagnostic X-rays ə acupuncture ə chemotherapy ə transfusion ə bone in a cast or immobilized ə

Chemical Stress Birth History

23. Was your mother regularly taking any drug prior to or during her pregnancy with you? Alcohol ə Smoking ə
24. Was her labor chemically induced or altered? Yes ə No ə
25. Was your mother: conscious ə semiconscious ə unconscious ə during your delivery? -
26. Any other chemical stress that your mother may have been subject to: _____

_____

General Chemical Stress

27. Are you now taking any drug (prescription or over-the-counter) regularly? Please list:

Drug: _____ Reason: _____

Drug: _____ Reason: _____

Drug: _____ Reason: _____

Are these drugs being prescribed by a physician? _____ Last visit: _____

28. Were you previously taking any medication regularly? _____

_____

29. Do you work with any chemical, fume, dust, powder, or smoke for prolonged periods? _____

_____

30. Please circle any dietary selection that is appropriate for you, and grade according to the following scale:

O - Do not consume this
M - Consume this monthly
FM - Consume this a few times per month (< weekly)
FD - Consume this a few times per day
W - Consume this weekly.
FW - Consume this a few times per week
D - Consume this daily

Alcohol _____	Eggs _____	Beef _____
Coffee _____	Cooked Vegs _____	Poultry _____
Tobacco _____	Raw Vegs _____	Fish _____
Artificial Sweeteners _____	Fruit _____	Seafood _____
Soda _____	Whole Grains _____	Weight Control _____
Diet Food _____	Dairy _____	Fasting _____
Refined Sugar _____	Fried Foods _____	Organic Foods _____

The kind of diet I usually follow is classified as: _____

Emotional / Mental Stress Birth History

31. My birth was: at home ə in a birthing center ə in a hospital ə

32. Were you incubated or isolated after birth? _____

33. Were you: bottle fed formula ə bottle fed mother's milk ə nursed ə nursed and bottle fed ə

General Emotional / Mental Stress

With each of the following spinal stress situations and potential cause of vertebral subluxations, please check either "P" for Past or "C" for Current or both as they apply ..

	MILD		MODERATE		EXTREME			MILD		MODERATE		EXTREME	
	P	C	P	C	P	C		P	C	P	C	P	C
Childhood Stress	ə	ə	ə	ə	ə	ə	Work Related Stress	ə	ə	ə	ə	ə	ə
School Stress	ə	ə	ə	ə	ə	ə	Stress of Commuting	ə	ə	ə	ə	ə	ə
Play, or Recreational	ə	ə	ə	ə	ə	ə	Loss of loved one	ə	ə	ə	ə	ə	ə
Family Stress	ə	ə	ə	ə	ə	ə	Change in lifestyle	ə	ə	ə	ə	ə	ə
Personal Relationships	ə	ə	ə	ə	ə	ə	Change in vocation	ə	ə	ə	ə	ə	ə
Stress of being sick	ə	ə	ə	ə	ə	ə	Abuse	ə	ə	ə	ə	ə	ə

34. How do you grade your physical health? Excellent ə Good ə Fair ə Poor ə Getting Better ə Getting Worse ə

35. How do you grade your emotional-mental health? Excellent ə Good ə Fair ə Poor ə Getting Better ə Worse ə

36. If you consider yourself ill, why do you feel you are ill? _____

_____

37. If you consider yourself well, why do you feel you are well? _____

_____

38. Is there anything else which may help to better understand you which has not been discussed?_____

_____

_____

_____

_____