

Rustici & Associates Chiropractic, P.C.

Patient Name: _____

Date: _____

Patient Account Code _____

Medical History

1. Was Your Birth Traumatic?

Long/Difficult Delivery	? Yes	? No	Chiropractor's Notes: _____
Forceps	? Yes	? No	Chiropractor's Notes: _____
Breach/cephalic	? Yes	? No	Chiropractor's Notes: _____
Induces labor	? Yes	? No	Chiropractor's Notes: _____

2. Growth, Development & Current Health Habits? At any time have you...

Fell out of bed	? Yes	? No	Chiropractor's Notes: _____
Banged your head	? Yes	? No	Chiropractor's Notes: _____
Had any accidents	? Yes	? No	Chiropractor's Notes: _____
Fell while learning to walk	? Yes	? No	Chiropractor's Notes: _____
Spanked	? Yes	? No	Chiropractor's Notes: _____
Pulled by ear/chin	? Yes	? No	Chiropractor's Notes: _____
Chair pulled out when sitting	? Yes	? No	Chiropractor's Notes: _____
Fell down the stairs	? Yes	? No	Chiropractor's Notes: _____
Pulled by your arm	? Yes	? No	Chiropractor's Notes: _____
Have occasional stress	? Yes	? No	Chiropractor's Notes: _____
Have physical stress	? Yes	? No	Chiropractor's Notes: _____
Have mental stress	? Yes	? No	Chiropractor's Notes: _____

3. What is your Sleeping Posture?

? Side ? Stomach ? Back Chiropractor's Notes: _____

Have you seen a Chiropractor before? ? Yes ? No

Outcome of Care: _____

Social History

Please indicate beside each activity whether you engage in it:

O = Often S = Sometime N = Never

Vigorous Exercise	_____	Chiropractor's Notes: _____
Moderate Exercise	_____	Chiropractor's Notes: _____
Daily Exercise	_____	Chiropractor's Notes: _____
Alcohol Use	_____	Chiropractor's Notes: _____
Drug Use	_____	Chiropractor's Notes: _____
Tobacco Use	_____	Chiropractor's Notes: _____
Caffeine	_____	Chiropractor's Notes: _____
High Stress Activity	_____	Chiropractor's Notes: _____
Family Pressures	_____	Chiropractor's Notes: _____
Other – Specify*	_____	Chiropractor's Notes: _____

What are your favorite hobbies or activities you do now? _____

Are your current problems affecting these activities? _____

What activities are you looking forward to in your retirement? _____

Who would you like to be doing these with? _____

Family History

Please use checkmark, check all that apply.

CONDITIONS:	PATIENT	SPOUSE	CHILDREN	FATHER	MOTHER	BROTHER(S)	SISTER(S)
Age							
Living or Deceased							
Arthritis							
Artificial Bone/Joint							
Asthma / Hay Fever							
Breathing Problems							
Blood Disorders							
Cancer							
Carpal Tunnel							
Chest Pain/Tightness							
Constipation							
Depression							
Diabetes I/II							
Dizziness							
Fatigue							
Feet Cold							
Frequent Colds							
Hands Cold							
Headaches							
Heart Trouble							
High Blood Pressure							
Hysterectomy							
Indigestion							
Irritability							
Jaw Pain							
Kidney Trouble							
Lights Bother Eyes							
Loss of Balance							
Loss of Memory							
Loss of Smell							
Loss of Taste							
Menstrual Problems							
Migraine							
Nervousness							
Numbness							
Ringin g in Ears							
Scoliosis							
Shoulder/Arm Pain							
Sinus Trouble							
Sleeping Problems							
Stomach Trouble							
Thyroid							
Weight Gain							
Weight Loss							
Other – Specify *							

* Other: _____

On a scale of 1-10 (10 being the most and 1 being the least)

_____ How committed are you to reaching your maximum health potential?

_____ How important is it to you for your family to realize their optimum health potential?

_____ How committed are you to maximizing your spinal stability?

Upon the completion of your first visit, you receive a Chiropractic Report to discuss the Active Life Plan that is 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 Chiropractic Active Life Plans prior to your Chiropractic Report appointment so you can choose the level of participation that supports you in reaching all of your health goals.

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

Please check all that apply

- Feel better quickly
- Have a healthier spine/Live a healthier life
- Have a healthier body by keeping my nerve system healthy
- I prefer the Doctor to select the care he feels is best for my lifestyle

In your own words...

In order for us to better understand your needs and create a more complete health relationship, please share with us the following information.

What is your health philosophy and in order to meet your future health goals, what actions will you take to meet your optimum health possibilities?

Signature

Date

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 lifetime involvement in health and wellness via 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.

**** For Chiropractor's Use Only ****

