

**ADVANCED CHIROPRACTIC WELLNESS CENTER  
SCOTT STRATTON, D.C.**

***Personal and Family Health History***

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ (Age \_\_\_\_\_)  
Date \_\_\_\_\_ Referred By \_\_\_\_\_  
Address \_\_\_\_\_ Occupation \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Employer \_\_\_\_\_  
Phone: (H) \_\_\_\_\_ Marital Status    S    M    D    W  
(W) \_\_\_\_\_ Spouse's Name \_\_\_\_\_  
(C) \_\_\_\_\_ Spouse's Occupation \_\_\_\_\_  
Email \_\_\_\_\_

***Number of Children and Ages***

***Previous Chiropractic Care?***

Name _____	Age _____	Yes _____	No _____	Reason _____
Name _____	Age _____	Yes _____	No _____	Reason _____
Name _____	Age _____	Yes _____	No _____	Reason _____
Name _____	Age _____	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. Through your examination and through your lifetime involvement in chiropractic / metabolic care, we will work to remove these interferences to your natural health expression so that you can live the quality of life you deserve.

***Current Health Condition***

Present Complaint (be brief) Reason For Your Visit Today

Major \_\_\_\_\_

What caused this problem and when ? \_\_\_\_\_

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? \_\_\_\_\_

**Current Health Condition Continued**

Is this condition getting progressively worse? \_\_\_\_\_

Other Doctors seen for this condition \_\_\_\_\_

Have you been under drug and medical care? \_\_\_\_\_

What medications are you taking? \_\_\_\_\_

How Long? \_\_\_\_\_ Surgeries? \_\_\_\_\_ What? \_\_\_\_\_ When? \_\_\_\_\_

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

**Other symptoms:**

- Headaches
- Migraines
- Insomnia
- Sleepy
- Chronic pain
- Diabetes
- Arrhythmia
- High blood pressure
- Colitis
- Itching
- Dizziness
- Allergies
- Seizures
- PMS
- Decreased urination
- Increased urination
- Fatigue
- Depression
- Anemia
- Auto Immune
- Rheumatoid Arthritis
- Arthritis
- Asthma
- Diarrhea
- Ulcers
- Constipation
- Vertigo
- Indigestion

**Chiropractor's  
Comments**

**Check all that Apply**

**1. Was Your Birth Traumatic?**

Long Delivery \_\_\_\_ Difficult Delivery \_\_\_\_ Forceps \_\_\_\_ Caesarian \_\_\_\_ Breach/cephalic \_\_\_\_

Home birth \_\_\_\_ Mother given drugs during delivery \_\_\_\_ Induced Labor \_\_\_\_

**2. Current Health Habits**

Smoke \_\_\_\_ Drink \_\_\_\_ Diet (do you eat healthy foods?) \_\_\_\_ Exercise regularly \_\_\_\_

Hobbies \_\_\_\_ artificial sweeteners \_\_\_\_ sleeping posture: side – stomach – back

**3. Injury History**

List physical injuries and when (auto, sports, falls, etc.) \_\_\_\_\_

\_\_\_\_\_

List history of chemical stress \_\_\_\_\_

List history of emotional/mental stress (loss of loved ones) \_\_\_\_\_

**4. Family History**

	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"/>

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

***Please check all that apply***

- Feel better quickly
- Have a healthier body by keeping my nerve system healthy
- Have a healthier spine
- Live a healthier lifestyle
- Have a healthier body by keeping my biochemistry / metabolic system healthy

Please list all nutritional supplements that you take (ie minerals, vitamins, herbs, homeopathics, flower essences, remedies, etc.), and approximately how long you have taken them:

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Please list all forms of exercise that you do currently (ie walking, weight training, yoga, aerobics, etc.), how long, and how often you exercise:

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Signature \_\_\_\_\_

Date \_\_\_\_\_