# CARMEL CHIROPRACTIC HEALTH HISTORY

Today's Date _____

## PERSONAL DATA

Name _____ Date of Birth _____

Both Parents' names (if you are under 18) _____

Home Address _____Town _____State _____Zip _____

Home Phone (  ) _____Cell Phone (  ) _____

Email address _____Social Security # _____

Driver's License # _____Occupation: _____ Employer _____

Marital Status: S M D W L/W Spouse/Partner _____

Names and Ages of Children: _____

**Whom may we thank for referring you to our office?** _____

## REASON FOR SEEKING CHIROPRACTIC CARE

What concerns do you feel Carmel Chiropractic can address for you?_____

_____

Are these concerns affecting your quality of Life? (Please circle all that apply)

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Work | Y | N | Driving | Y | N | Sleep | Y | N |
| School | Y | N | Walking | Y | N | Sitting | Y | N |
| Exercise/sports | Y | N | Eating | Y | N | Love Life | Y | N |

## HEALTH CARE PRACTITIONER HISTORY

**Have you ever received Chiropractic care? Y N** **Name of D.C.** _____

How long under care? _____ days _____ weeks _____ months _____ years

Date of last visit _____. Why did you stop care? _____

Have you consulted or do you regularly consult any of the following providers? (check all that apply)

| | | | |
|---|---|---|---|
| Medical Physician _____ | Naturopath _____ | Acupuncturist _____ | Homeopath _____ |
| Massage Therapist _____ | Psychotherapist _____ | Energy Healer _____ | Dentist _____ |

Reason: _____

_____

## FOR WOMAN

**Are you pregnant? Y N** **Date of last menstrual period** _____

If X-rays are recommended, your signature is required to verify that you are not pregnant.

**Signature** _____**Date** _____

If pregnant, Due date_____Name Of OB/GYN 0T Midwife _____

Where will _you be birthing your baby? Hospital _____Home _____ Birthing Center_____Other _____

# HEALTH, WELLNESS AND CHIROPRACTIC CARE

**The primary system in the body which coordinates health is the NERVE SYSTEM.**
**The vertebrae (bones of the spinal column) surround and protect the delicate NERVE SYSTEM.**
**Injury to the SPINE and NERVE SYSTEM is a condition call VERTEBRAL SUBLUXATION.**
**VERTEBRAL SUBLUXATION results in nerve malfunction due to vertebral/spinal misalignment.**
**Vertebral Subluxations can have Physical, Emotional and Chemical causes and effects.**

The information below will help us to see the types of PHYSICAL, EMOTIONAL & CHEMICAL stresses you have been subjected to in your life, how they may relate to your present spinal, nerve and health status and whether they may have caused Vertebral Subluxations to occur.

## PHYSICAL STRESS: BIRTH AND INFANCY

The birth process can traumatize a baby's spine and cause damage to the spine and nerve system. Please CHECK where and how you were birthed. (If you do not know, please skip to the next question.)

Home _____ Natural _____ Hospital _____ Caesarian Section _____ Forceps _____
Breech _____ Cord around neck _____ Prolonged labor _____ Drug induced labor _____ Suction _____

## PHYSICAL STRESS: CHILDHOOD THROUGH ADULT

The minor & often Ignored repetitive physical traumas that we have endured are often too numerous to list. Please fist the major traumas that you remember from childhood to the present. Have you had any accidents due to any of the following? (Check all that apply.)

Automobile ____ Motorcycle ____ Bicycle ____ Sports ____ Playground ____ Abuse ____

If yes, state type of injury and date: _____

Have you ever hurt, broken, fractured, sprained, injured or felt pain in any bones of joints (spine, head, neck, ribs, chest, upper or lower back, pelvis or hips, legs or arms? Y N

If yes, list body parts injured and dates of injuries _____

Have you ever been hospitalized or had surgery? Y N

If yes, state reason and dates _____

## EMOTIONAL STRESS: CHILDHOOD THROUGH ADULT

It is difficult to separate the emotional stress in our life from the physical response that often occurs. Please indicate if you have ever, or are currently, experiencing any of the emotional stresses below:

| | | | | | |
|---|---|---|---|---|---|
| Childhood trauma | Y N | Loss of loved one | Y N | Abuse | Y N |
| Work or School | Y N | Divorce/separatton | Y N | Financial | Y N |
| Lifestyle change | Y N | Parents' divorce | Y N | Illness | Y N |

## CHEMICAL STRESS: CHILDHOOD THROUGH ADULT

Chemical stress can occur when a substance that is toxic to the body is breathed, injected, taken by mouth or placed on the skin (e.g. food allergies, drug reactions, exposure to chemicals in the air, etc.) The following will reveal exposures you may have had.

Were you vaccinated? Y N If yes, did you have a reaction? Y N Unsure

Have you been exposed to any of the following on a regular basis (in the past or present?)

| | | |
|---|---|---|
| Toxic chemicals _____ | Second hand smoke _____ | Drug therapy _____ |
| Radiation _____ | Chemotherapy _____ | Other _____ |

if yes, please list: _____

Do you have allergies or sensitivities to any foods? Y N If yes, please list _____

_____

Coffee/caffeine _____ Alcohol _____ Tobacco _____ Over the counter drugs _____ Prescribed drugs _____

Please fist all medications (prescribed and OTC) _____

_____

**Note: It Is imperative that you list all medications as they may have an influence on your care.**

## QUALITY OF LIFE (presently)

| | | | |
|---|---|---|---|
| How do you grade your physical health? | Good | Fair | Poor |
| How do you grade your emotional health? | Good | Fair | Poor |
| How do you rate your overall "quality of life?" | Good | Fair | Poor |

Do you exercise regularly? If yes, how often? _____

Do you take supplements? If yes, please list. _____

Do you follow a special dietary regime? _____

## YOUR EXPECTATIONS FROM CHIROPRACTIC CARE

I would like to experience the following benefits from Chiropractic Care: (Check all that apply.)

Relief of a symptom or problem _____

Relief and prevention of a symptom or problem _____

Healthier spine and nerve system _____

Optimal health on all levels _____

Other

_____

**What are your health goals?**

more energy _____
better concentration _____
reduce/eliminate medication use _____
deeper relaxation _____
overall health improvement _____
better sleep _____
easier breathing _____
improved strength & endurance _____
better sports performance _____
other goals _____
freedom from pain _____
enhanced emotional well-being _____
greater resistance to disease _____
more balanced posture _____

_____

## INFORMATION ABOUT FINANCES

**Payment In full is expected on all FIRST VISIT services** (whether you have insurance coverage or not.) All other fees *are* to be paid at time of service until other arrangements have been made and agreed upon.

Please indicate your method of payment: Cash_____ Check _____ Credit Card (type) _____

Credit card # _____ exp _____

**First Visit Fees: Comprehensive exam, inducting scan of nerve system $175**

if you have insurance that you would like to use, please follow instructions below.
If not, please be sure to read about our affordable direct payment plans for you and your family.

## INSURANCE INFORMATION

Insurance coverage varies greatly. We cannot predict whether your policy will cover the services we provide in our office. If you want to use your insurance, please allow us to make a copy of your insurance card so that we may verify your coverage for Chiropractic. We will also need the following information:

Name of primary insured: _____ His/her DOB: _____

His/her social security number: _____

Insurance policy #_____

Name of insurance co and/or name of employer: _____

All accounts not paid within 90 days will *automatically* be charged to your credit card.

## PLEASE READ AND SIGN

1) I have been informed that a copy of Carmel Chiropractic's *"Notice of Privacy Practices for Protected Health Information"* (HIPAA) brochure is available for my review in the office.

2) I consent to receive communication from CC via email, postal mail, text and telephone messaging in connection with my care. Y N If I should withdraw my consent, I will notify the office in writing.

The information I have provided on this case history is true and accurate to the best of my knowledge. I give Dr. Adrienne Fabrizio permission to render care to me today. This initial visit includes a health history consultation, chiropractic exam and evaluation, and any initial care that is determined to be clinically necessary and mutually agreed upon.

Signature _____Date _____

Signature of Parent (for minor) _____

Doctor's signature _____