



PERSONAL HISTORY QUESTIONNAIRE

Date: ___/___/___

Name: _____ Address: _____

City: _____ State: _____ Zip: _____ Occupation: _____

E-Mail: _____ Home Phone: _____ Business Phone: _____

Date of Birth: _____ Age: _____ M F Marital Status: _____ No. of Children: _____

Social Security Number:(optional) _____ Insurance: _____

How did you hear about our office? _____

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT YOUR PERSONAL HISTORY:

1. Have you ever had your spine or nervous system examined professionally? Yes No
2. Have you ever received Network Spinal Analysis care? Yes No Network Chiropractic care? Yes No
If yes, when was your last visit? _____ For how long were you going? _____
How often did you go? _____ If you stopped, why did you stop going? _____
3. Were you pleased with his or her service? Yes No
4. Does your immediate family receive Network Care? Yes No
5. Have you had, or do you receive the following vehicles towards healing or growth?
If yes, please list when and any comments you wish to share:
Chiropractic: Yes No _____
Bodywork / massage: Yes No _____
Osteopathy / cranial work: Yes No _____
Homeopathy/Accupuncture: Yes No _____
Meditation: Yes No _____
Psychotherapy: Yes No _____
Movement or exercise: Yes No _____
Somato Respiratory Integration: Yes No _____
Yoga: Yes No Prayer: Yes No Other: _____
Rebirthing / breathwork: Yes No _____
6. Do you currently have any health concerns? Yes No Please describe: _____

7. What do you hope to gain from the care in this office? _____

The practice of chiropractic is based upon the location and adjustment of vertebral subluxations. 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 in nature.

PHYSICAL HISTORY - BIRTH STRESS: If you have Information about your birth history:

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

<input type="checkbox"/> drug induced	<input type="checkbox"/> forceps or suction
<input type="checkbox"/> "C" section	<input type="checkbox"/> Cord around the neck
<input type="checkbox"/> breech	<input type="checkbox"/> prolonged
<input type="checkbox"/> Natural	<input type="checkbox"/> Other: _____
6. Describe any other physical or mechanical stress to your mother or you as labor progressed, delivery progressed, or as a newborn.

GENERAL PHYSICAL TRAUMA:

7. Next to each potential vertebral subluxation cause is a check box. Please check the appropriate box - either 'P' for past or 'C' for current, and the correct level of trauma: 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, carriage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	Sports impacts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Falls down or up steps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Physical fight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Falls on ice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Armed services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments: _____

8. Were you ever knocked unconscious? Yes No
Comments: _____

9. Have you ever used crutches, a walker, or cane? Yes No
Comments: _____

10. Have you ever broken any bones? Yes No
Comments: _____

11. Have you ever had any impacts, falls, or jolts that you feel specifically may have injured your spine? Yes No
Comments: _____

12. Have you had extensive dental or orthodontial work performed? Yes No
Comments: _____

13. Have you served in the military? Yes No From _____ to _____ Were you involved in combat? Yes No

14. During the day I: sit stand walk do desk work phone work drive do mechanical work heavy lifting

15. I exercise: daily weekly monthly Describe: _____

SPORTS or LEISURE:

16. Were you, or are you active in any particular sport(s)? Yes No
Which one(s)? _____

17. Have you been hurt in any of these activities? Yes No
Comments: _____

- 18 Do you read for prolonged periods? Yes No
- 19 Do you play a musical instrument? Yes No
- 20 Do you have a particular position for watching television? Yes No

Comments: _____

- 21 I wear: Glasses Bifocals Contact lenses

AUTOMOBILE ACCIDENTS:

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

Automobile: _____

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

MEDICAL TREATMENT:

- 23 Have you ever been hospitalized? Yes No If yes, what was actually done to you? _____

24 Have you had surgery? _____

25 Do you still have all your body parts? _____

- 26 Have you had: a spinal tap spinal injections physiotherapy neck collar spinal brace traction heel lift
 x - ray treatments corrective shoes or bars on shoes extensive diagnostic x - rays acupuncture
 chemotherapy transfusion body part in a cast or immobilized?

CHEMICAL HISTORY - BIRTH STRESS:

- 1 Was your mother regularly taking any drug immediately prior to, or during her pregnancy with you? Alcohol Smoking

Other?: _____

- 2 Was her labor chemically induced or altered? Yes No

- 3 Was your mother: conscious semiconscious unconscious during your delivery? Under spinal anesthesia during delivery?

4 Any other chemical stress that your mother may have been subject to during pregnancy or labor?: _____

GENERAL CHEMICAL TRAUMA:

- 5 Are you now taking any drug (prescription or over-the-counter) regularly? Please list drugs, when prescribed and reasons for taking them: _____

Are these drugs being prescribed by a physician? Yes No Last visit: _____

6 If you were previously taking any medication regularly? Please describe: _____

- 7 Do you or did you work with any chemical fume, dust, powder, smoke for prolonged periods? Yes No

8. Please grade any dietary selection that is appropriate for you using the following scale:

- 0 - Do not consume this
- M - Consume this monthly
- FM - Consume a few times per month (less than 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

- | | | |
|--|--|--|
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Eggs | <input type="checkbox"/> Beef |
| <input type="checkbox"/> Coffee | <input type="checkbox"/> Cooked, canned vegetables | <input type="checkbox"/> Poultry |
| <input type="checkbox"/> Tobacco | <input type="checkbox"/> Raw Vegetables | <input type="checkbox"/> Fish |
| <input type="checkbox"/> Artificial Sweeteners | <input type="checkbox"/> Fruit | <input type="checkbox"/> Seafood |
| <input type="checkbox"/> Soda | <input type="checkbox"/> Whole Grains | <input type="checkbox"/> Weight Control Diet |
| <input type="checkbox"/> Diet Food | <input type="checkbox"/> Dairy (milk products) | <input type="checkbox"/> Fasting |
| <input type="checkbox"/> Refined Sugar | <input type="checkbox"/> Fried Foods | <input type="checkbox"/> Organic Foods |

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

EMOTIONAL HISTORY - BIRTH STRESS:

1. My birth was: at home in a birthing center in a hospital other
2. Were you incubated or isolated after birth? Yes No
3. Were you bottle fed formula bottle fed mother's milk nursed nursed and bottle fed?

GENERAL EMOTIONAL TRAUMA:

4. With each of the following potential spinal stress situations, please check either "P" for past or "C" for current.

	MILD		MODERATE		EXTREME			MILD		MODERATE		EXTREME	
	P	C	P	C	P	C		P	C	P	C	P	C
Childhood stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Work related stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
School stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stress of commuting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Play, or recreational	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loss of loved one	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Change in lifestyle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Personal relationships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Change in vocation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stress of being sick	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5. How do you grade your physical health? Excellent Good Fair Poor Getting Better Getting Worse
6. How do you grade your emotional/mental health? Excellent Good Fair Poor Getting Better Getting Worse

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

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

9. Is there anything else you may wish to share which may help us to better understand you, and why you have chosen to see the doctor in this office? _____
