Humfeld Family Chiropractic, P.C.

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www.humfeldchiropractic.com

Your Full Name: ______________________ Today's Date: ______________________

Address: ______________________ Home Phone: ____________ Cell Phone: ____________

______________________ Business Phone: ____________ Email: ______________
(your email address is for office use only and will not be sold)

Birth Date: __________ SS#: ______________ Do you have Medicare: Yes _____ No _____

Spouse's Name: ______________________ Children (ages): ______________________

Your Employer: ______________ Occupation: ______________ Years on Job: ____________

Previous Chiropractor: ______________ City: ____________ Date of last visit: ______________

What type of care did you receive? (Relief/ Correction/ Wellness) Did you follow their recommendations? Yes _____ No _____
If not, why not? ______________________

Reason for Changing Chiropractors: ______________________________________

Reason for contacting our office: ____Relief of Symptoms ____Corrections of Problem ____Wellness care of optimizing your personal or family's health

Present MD: ______________ City: ____________ Referred to our office by: ______________

Contact Name in case of an Emergency: ____________________ Phone #: ____________________

Adult Consultation History

Your Primary Health Concern(s): ______________________________________

Other concerns (in order of importance): ______________________________________

How long have you dealt with this issue(s)? __________ How did it start?______________________

What have you tried to do to address this issue(s) that DID NOT work? ______________________

Has anything given you temporary relief? ______________________________________

What is the pattern of this issue(s)? Constant _____, Intermittent _____, Occasional _____, Cyclic _____

What makes it worse? ______________________________________

At its worst, how does it make you feel? ______________________________________

How does this issue(s) interfere with the following areas? Work: ______________________

Family: ________________Hobbies: ________________ Life: ________________

Have you become discouraged about handling this challenge? ______________________

How much older does this make you feel? ________ When was the last time you felt your best? (How long ago?) ____________

On a scale of 1 to 10, with 10 being the highest, rate your commitment in helping us find a solution to this health concern: ________

What are your health goals and expectations? ______________________________________

On a daily basis we experience physical, chemical and emotional stresses that can accumulate and result in loss of health potential. Usually the effects are gradual, not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential.

Have you been involved in any auto accidents, experienced significant injuries, or serious illnesses? ____________________________
If yes, give details: ____

Have you had any surgeries? _______ If yes, when and why? ____

____

Have you ever fractured a bone? Yes ____ No____ If yes, what bone(s)? ____

____

Are you on any type of medication? ______ Please list all and reason: ____

____

Do you take vitamins or minerals? Yes ____ No ____ If yes, what? ____

____

How stressful is your life? (rate on a scale of 1 to 10, with 10 being the highest) Occupation ___________ Personal ______________

What do you feel is your primary stress? ____

Do you have any children? ________ Do they have any health problems that you are aware of? ________________________________

____

Is there any other information you would like us to know? ____

____

Signature: ____ Date: ____

For Women Only

Date of your last menstrual period: __________________________________

Are you using any means of contraception: ____________________________

Do you experience serve cramping with your menstrual period? __________

Do you suffer from PMS? ____

Name: ____________________________________ Date: ______________________

CHEMICAL BALANCE QUESTIONAIRE

Speed of healing is determined by **chemical balance** in the body. Chemical balance is Determined, in large, by **what you eat.** Please indicate the amounts and frequencies you partake in the following foods and beverages. This is not a test, but it lets us know how to help you better, so please be honest when answering:

	Per Day	Per Week
1. Coffee (caff/decaff)	____ cups	____ cups
2. Tea (herbal/regular)	____ cups	____ cups
3. Sugar, sweets, desserts, candy artificial sweetener	____ times	____ times
4. Salt, salty snacks, chips, etc.	____ servings	____ servings
5. Do you add salt to food at meal time?	___ yes ___ no	___ sometimes
6. Red meat (beef, pork, bacon, ham, etc.)	____ times	____ times
7. Chicken/Fish	____ times	____ times
8. Dairy (milk, cheese, ice cream, etc.)	____ times	____ times
9. Water	____ glasses	____ glasses
10. Fresh Fruits	____ pieces	____ pieces
11. Fresh Vegetables (non-canned)	____ servings	____ servings
12 Alcoholic Beverages	____ servings	____ servings
13. Soft Drinks (caff/decaff)	____ servings	____ servings
14. Smoking	____ packs	____ packs

What is a typical breakfast for you? ____
What is a typical lunch for you? ____
What is a typical evening meal for you? ____
List any vitamins/herbs you are currently taking? _____________________________________
____

Confidential Patient Case History

Dear Patient: Please complete this questionnaire. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. THANK YOU.

Name: ____ Date: ______________________

Please check the appropriate box for any of the following symptoms that you now have or have had previously. Leave it blank if you have NOT experienced the condition noted. We need all the facts about your health before we accept your case.

THIS IS A CONFIDENTIAL HEALTH REPORT.

O=OCCASIONAL F=FREQUENT C= CONSTANT P=PAST

GENERAL

______Allergy
______Chills
______Convulsions
______Dizziness
______Fainting
______Fatigue
______Fever
______Headache
______Loss of sleep
______Loss of weight
______Nervousness/depression
______Neuralgia
______Numbness
______Sweats
______Tremors

MUSCLE & JOINT

______Arthritis
______Bursitis
______Foot trouble
______Hernia
______Low back pain
______Lumbago
______Neck pain or stiffness
______Pain between shoulders
______Pain or numbness in:
______ Shoulders
______ Arms
______ Elbows
______ Hands
______ Hips
______ Legs
______ Knees
______ Feet
______Painful tailbone
______Poor posture
______Sciatica
______Spinal Curvature
______Swollen joints

GASTRO-INTESTINAL

______Belching or gas
______Colitis
______Colon trouble
______Constipation
______Diarrhea
______Difficult digestion
______Distension of abdomen
______Excessive hunger
______Gall bladder trouble
______Hemorrhoids
______Intestinal worms
______Jaundice
______Liver trouble
______Nausea
______Pain over stomach
______Poor appetite
______Vomiting
______Vomiting of blood

EYES, EARS, NOSE & THROAT

______Asthma
______Colds
______Crossed eyes
______Deafness
______Dental decay
______Earache
______Ear discharge
______Ear noises
______Enlarged glands
______Enlarged thyroid
______Eye pain
______Failing vision
______Far sightedness
______Gum trouble
______Hay fever
______Hoarseness
______Nasal obstruction
______Near sightedness
______Nosebleeds
______Sinus infection
______Sore throat
______Tonsillitis

CARDIO-VASCULAR

______Hardening of arteries
______High blood pressure
______Low blood pressure
______Pain over heart
______Poor circulation
______Rapid heart beat
______Slow heart beat
______Swelling of ankles

RESPIRATORY

______Chest pain
______Chronic cough
______Difficult breathing
______Spitting up blood
______Spitting up phlegm
______Wheezing

SKIN

______Boils
______Bruise easily
______Dryness
______Hives or allergy
______Itching
______Skin eruptions (rash)
______Varicose veins

GENITO-URINARY

______Bed-wetting
______Blood in urine
______Frequent urination
______Inability to control kidneys
______Painful urination
______Prostate trouble
______Pus in urine

FOR WOMEN ONLY

______Congested breasts
______Cramps or backache
______Excessive menstrual flow
______Hot flashes
______Irregular cycle
______Menopausal symptoms
______Painful menstruation
______Vaginal discharge
____Yes ____No Are you pregnant?

CHECK THE FOLLOWING CONDITIONS YOU HAVE HAD:

Alcoholism	Cold sores	Goiter	Miscarriage	Scarlet fever
Anemia	Diabetes	Gout	Multiple sclerosis	Stroke
Appendicitis	Diptheria	Heart disease	Mumps	Tuberculosis
Arteriosclerosis	Eczema	Influenza	Pleurisy	Typhoid fever
Arthritis	Emphysema	Lumbago	Pneumonia	Ulcers
Cancer	Epilepsy	Malaria	Polio	Venereal disease
Chorea	Fever blisters	Measles	Rheumatic fever	Whooping cough