Patient Health History

Blanton Family Chiropractic
1216 6th Avenue Huntington, WV 25701
Phone: (304) 523-3333 Fax: (304)523-3330

Name: _____DOB:_____Date: _____

Address: _____City: _____

State: _____ Zip: _____ Social Security #:_____

Email: _____Occupation: _____

Phone: (____)_____-_____Cell: (____)_____-_____Work: (____)_____-_____ (ext:____)

Married Single Divorced Widowed Kids: _____(#)

Childhood History: *Circle all that apply*

Did you have any childhood illnesses?	**Yes**	**No**
Did you have any serious falls as a child?	**Yes**	**No**
Did you play youth sports?	**Yes**	**No**
Did you take Medications?	**Yes**	**No**
Did you have surgery?	**Yes**	**No**
Have you fallen / jumped from a height over three feet?	**Yes**	**No**
Were you in any car accidents as a child?	**Yes**	**No**
Was there any prolonged use of medicine such as antibiotics or an inhaler?	**Yes**	**No**
Did you suffer any other traumas (physical or emotional)	**Yes**	**No**
As a child, were you under regular chiropractic care?	**Yes**	**No**

Please share any additional information:

_____

_____

Adult – (18 to present)

Rate these following as Poor, Good, Excellent:

General Health: Poor Good Exellent

Diet: Poor Good Exellent

Sleep: Poor Good Exellent Hours per day? _____

Do/did you smoke? Past Present No (circle one)
If yes, #_____ packs per day week month year (circle one)

Do/did you drink alcohol? Past Present No (circle one)
If yes, # _____ drinks per day week month year (circle one)

Have you been in any accidents? Yes No

If yes, when?_____

Describe what happened:_____
_____

Exercise? Yes No Type: _____ Times per week:_____ Length:_____

Have you had any surgery? Yes No
If yes, list here: _____

Do/did you play adult sports? Yes No If yes: _____

Please list any medications: _____
_____
_____

On a scale of 1 – 10 describe your stress level: (1 = none / 10 = extreme)
Occupational: _____ Personal:_____

<u>Addressing issues that may have brought you to our office</u>
If you have no symptoms or complaints, and are here for wellness services, please check here ☐ and then skip to Family Health Profile. Otherwise please briefly explain what brought you to our office today:

_____
_____
_____

Does this interfere with:
___Work ___Sleep ___Walking ___Hobbies ___Leisure ___Other
Have you seen anyone else for this issue? ____yes _____no If yes, who?
_____
_____

Please check (✓) all symptoms you have ever had, even if they do not seem related to your current problem:

□ Headaches	□Pins and needles in legs	□ Fainting	□ Neck pain
□ Pins and needles in arms	□Loss of smell	□ Back Pain	□ Loss of balance
□ Dizziness	□ Buzzing in ears	□ Ringing in ears	□ Nervousness
□ Numbness in fingers	□Numbness in toes	□ Loss of taste	□Stomach Upset
□ Fatigue	□ Depression	□ Irritability	□ Tension
□ Sleeping problems	□ Stiff Neck	□ Cold Hands	□ Cold Feet
□ Diarrhea	□ Constipation	□ Fever	□ Hot Flashes
□ Cold Sweats	□ Lights bother eyes	□ Urinary Problems	□ Heartburn
□ Mood Swings	□ Menstrual Pain	□ Menstrual Irrgularity	□ Ulcers

Family Health Profile:

At our office we are not only interested in your health and wellbeing but also that of your family and loved ones. Please mention below any health conditions or concerns you may have about your:

Children:

_____

Spouse:

_____

Mother:

_____

Father:

_____

Brother(s):

_____

Sister (s):

_____

Others:

_____

Do you:

Drink Bottled water? **Yes No**

Belong to health club? **Yes No**

Use vitamins?	**Yes**	**No**	
Watch more than 5 hours of TV a week?	**Yes**	**No**	
Spend 1 or more hours on a computer daily ?	**Yes**	**No**	
Drink Soda?	**Yes**	**No**	**(Diet or Regular)**

What do you do for stress relief?

_____

_____

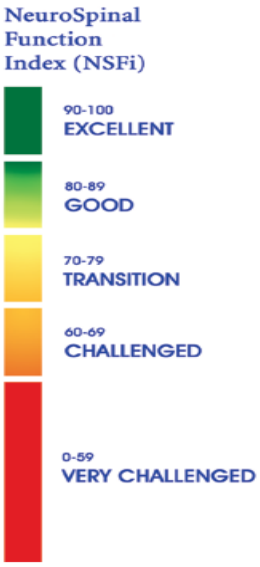
Are there any other health habits that you could share with us?

_____

_____

_____

Please mark an "X" where you believe your health is and an "O" where you would like to be.



I consent to a professional and complete chiropractic examination and to any radiographic examination that the doctor deems necessary. I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

Signature: _____Date:_____