DENETTE FAMILY CHIROPRACTIC HEALTH HISTORY FORM

Please fill out this form as completely and accurately as possible.

Today's Date_____

Name_____ Age _____ Date of Birth _____

Parent's names (if you are under 18) _____

Home Address_____ City _____ State_____ Zip _____

Home phone (____) _____ Business Phone (____) _____

Cell Phone (____) _____E-mail address_____

Occupation_____Employer _____

Business Address_____ City_____State____ Zip _____

SS# (opt'l)_____ Emergency contact _____

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? _____

What concerns do you feel Denette Family Chiropractic can address for you?

_____

_____

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

Work/School:	Y	N	Driving:	Y	N	Sleep:	Y	N	Love life:	Y	N
Eating:	Y	N	Walking:	Y	N	Sitting:	Y	N	Exercise:	Y	N

On a scale of 1-10, how much is this affecting your life?

Little affect *Great affect*

1 2 3 4 5 6 7 8 9 10

I would like to have 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

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?_____

FOR WOMEN

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

If **pregnant**, Due Date: _____ Name of OBGYN or Midwife _____

DENETTE FAMILY CHIROPRACTIC HEALTH HISTORY FORM

Please list the traumas that you remember from your childhood up to the present.
(check all that apply)

❑ Automobile ❑ Motorcycle ❑ Bicycle ❑ Sports ❑ Playground ❑ Abuse

If yes, state type of injury and date of injury:

_____

_____

Have you ever hurt, broken, fractured or sprained, injured or felt pain in any bones or 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: _____

Please indicate if you have experienced 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/separation	Y	N	Financial	Y	N
Lifestyle change	Y	N	Parents divorce	Y	N	Illness	Y	N

Do you consume any of the following presently?

❑ Coffee/caffeine ❑ Alcohol ❑ Tobacco ❑ Medications

Please list all medications (prescribed and over the counter):_____

_____

_____

_____

How do you grade your physical health? ❑ Good ❑ Fair ❑ Poor

How do you grade your emotional/mental health? ❑ Good ❑ Fair ❑ Poor

How do you rate your overall "quality of life"? ❑ Good ❑ Fair ❑ Poor

Aspects of wellness you want for yourself:

❒ More Energy	❒ Better Sleep	❒ Freedom from pain
❒ Better Concentration	❒ Enhanced emotional well-being	❒ Reduce medication use
❒ Improved digestion	❒ Improved strength and endurance	❒ Greater Resistance to disease
❒ Easier breathing	❒ Better sports performance, reaction time/reflexes	❒ Overall health improvement
❒ Deeper relaxation	❒ More balanced posture	❒ Other _____

DENETTE FAMILY CHIROPRACTIC HEALTH HISTORY FORM

FINANCES

There is no charge for the Initial Examination, or for the Report of Findings. Any financial questions will be answered at the Report of Findings.

INSURANCE INFORMATION

We will copy your insurance card on the first visit, and look into your benefits prior to the Report of Finances.

Insurance type: ❑ Medicare ❑ Auto Accident ❑ Workers Comp. ❑ Other (e.g. Tufts, BCBS, etc.) Insurance Name:_____

Is this an Auto Accident or a Work-Related Injury? ❑ **Yes** ❑ **No**
If yes, please provide us with the following information:
Have you been treated elsewhere? ❑ Yes ❑ No
If yes, where? ❑ Emergency Room ❑ Primary Care ❑ Other_____
What services were provided? ❑ MRI ❑ X-Rays ❑ Medication ❑ Therapy
❑ Other (details) _____

PLEASE READ AND SIGN

1. I have been informed that a copy of Denette Family Chiropractic's "Notice of Privacy Practices for Protected Health Information (HIPAA)" brochure is availale for my review both in the office and on the website at www.denettefamilychiropractic.com.

2. I consent to receive communication from Denette Family Chiropractic via email, postal mail, text and telephone messaging in connection with my care.
❒ Yes If I should withdraw my consent, I will notify the office in writing.
❒ No

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

Name: (Printed) _____

Signature_____ Today's Date_____

Signature of Parent (for minor):_____ Today's Date_____

Thank you for choosing Denette Family Chiropractic!
We look forward to helping you.