

Welcome to

Arciom Chiropractic Clinic

Thank you for choosing our office. We are committed to providing you and your family with the highest quality of chiropractic care available so that you heal quickly and enjoy an active, healthy, long life. We will be working together to help you and your family reach your health and lifestyle goals.

If you ever have any questions about your chiropractic care, please don't hesitate to ask one of our highly educated chiropractic team members.

Chiropractors have become the primary care doctors for millions of people around the world. Regardless of your reason for visiting our office today, our goal is to become your family's trusted provider and resource for living a healthy lifestyle throughout your lifetime.

Personal and Family Health History

Name _____
 Date _____
 Address _____
 City _____ State ____ Zip _____
 Phone: (H) _____ (W) _____
 E-mail _____
 Date of Birth _____ (Age _____)

Referred By _____
 Social Security # _____
 Occupation _____
 Employer _____
 Marital Status S M D W
 Spouse's Name _____
 Spouse's Occupation _____

Number of Children and Ages

Name _____
 Name _____
 Name _____
 Name _____

Age _____ Yes ___ No ___ Reason _____
 Age _____ Yes ___ No ___ Reason _____
 Age _____ Yes ___ No ___ Reason _____
 Age _____ Yes ___ No ___ Reason _____

Previous Chiropractic Care?

You deserve to be healthy. When you were conceived, you were given the blue-prints, intelligence, and systems to live an active, healthy, long life. Unfortunately, the natural expression of your health can be interfered with. Through your examination and through your involvement in chiropractic care, we will work to remove these interferences and keep them out of your life, so that you can heal quickly and live the quality lifestyle you deserve.

	<i>Patient</i>	<i>Spouse</i>	<i>Child#1</i>	<i>Child#2</i>	<i>Child #3</i>	<i>Chiropractor's Comments</i>
Circle all that Apply						
1. Was Your Birth Traumatic?						
Long Delivery?	Y	Y	Y	Y	Y	_____
Difficult Delivery?	Y	Y	Y	Y	Y	_____
Forceps?	Y	Y	Y	Y	Y	_____
Caesarian?	Y	Y	Y	Y	Y	_____
Breach/cephalic?	Y	Y	Y	Y	Y	_____
Home birth?	Y	Y	Y	Y	Y	_____
Mother given drugs during delivery	Y	Y	Y	Y	Y	_____
Induced Labor?	Y	Y	Y	Y	Y	_____
2. Growth and Development						
Did you ever once...						
Learn to care for your spine?	Y	Y	Y	Y	Y	_____
Fall out of bed?	Y	Y	Y	Y	Y	_____
Bang your head?	Y	Y	Y	Y	Y	_____
Breastfeed?	Y	Y	Y	Y	Y	_____
Childhood sickness?	Y	Y	Y	Y	Y	_____
Have any Accidents?	Y	Y	Y	Y	Y	_____
Have Surgery?	Y	Y	Y	Y	Y	_____
Take Drugs?	Y	Y	Y	Y	Y	_____
Fall while learning to walk?	Y	Y	Y	Y	Y	_____
Bullied by your siblings?	Y	Y	Y	Y	Y	_____
Child abuse	Y	Y	Y	Y	Y	_____
Spanking?	Y	Y	Y	Y	Y	_____
Pulled ear/chin	Y	Y	Y	Y	Y	_____
Other	Y	Y	Y	Y	Y	_____
Chair pulled out when sitting?	Y	Y	Y	Y	Y	_____
Fall down the stairs?	Y	Y	Y	Y	Y	_____
Pulled by your arm?	Y	Y	Y	Y	Y	_____
Experience other traumas?	Y	Y	Y	Y	Y	_____
3. Current Health Habits						
Did/do you...						
Smoke?	Y	Y	Y	Y	Y	_____
Drink	Y	Y	Y	Y	Y	_____
Diet (do you eat healthy foods?)	Y	Y	Y	Y	Y	_____
Have you been in accidents?	Y	Y	Y	Y	Y	_____
Have you had surgery and organs replaced/removed?	Y	Y	Y	Y	Y	_____

Drugs? (Prescriptive or Non-Prescriptive)	Y	Y	Y	Y	Y	_____
Have Teeth Problems?	Y	Y	Y	Y	Y	_____
Have Eye Problems?	Y	Y	Y	Y	Y	_____
Have Hearing Problems?	Y	Y	Y	Y	Y	_____
Exercise regularly?	Y	Y	Y	Y	Y	_____
Have sleeping problems? (nightmares)?	Y	Y	Y	Y	Y	_____
Have occupational stress?	Y	Y	Y	Y	Y	_____
Have physical stress?	Y	Y	Y	Y	Y	_____
Have mental stress?	Y	Y	Y	Y	Y	_____
Have hobbies/sports injuries?	Y	Y	Y	Y	Y	_____
Sleeping posture – side–stomach–back	_____	_____	_____	_____	_____	_____

Current Health Condition

Present Complaint or Crisis? If no current crisis, what is the reason for your visit today?
 Major _____
 Pain or Problem started on _____
 Pains are: Sharp Dull Constant Intermittent
 What activities aggravate your condition/pain? _____
 What activities lessen your condition/pain? _____
 Is condition worse during certain times of the day? _____
 Is this condition interfering with work? _____ Sleep? _____ Routine? _____ Other? _____
 Is this condition getting progressively worse? _____
 Other Doctors seen for this condition _____
 Any home remedies? _____

Other symptoms:

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Face Flushed | <input type="checkbox"/> Light Bothers Eyes | <input type="checkbox"/> Feet Cold |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Neck Stiff | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Hands Cold |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Pins & Needles in Legs | <input type="checkbox"/> Ears Ring | <input type="checkbox"/> Stomach Upset |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Pins & Needles in Arms | <input type="checkbox"/> Fever | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Numbness in Fingers | <input type="checkbox"/> Fainting | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Numbness in Toes | <input type="checkbox"/> Cold Sweats | <input type="checkbox"/> Buzzing in Ear |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Loss of Smell | |
| <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Loss of Taste | |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Depression | <input type="checkbox"/> Diarrhea | |

Have you been under drug and medical care? _____
 What medications are you taking? _____
 How Long? _____ Have you had surgery? _____ What? _____ When? _____
 What side effects have you experienced from the drugs and surgery? _____

Family History:

	Heart Disease	Arthritis	Cancer	Diabetes	Other _____
Father's Side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mother's Side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Your oldest grandparent on record lived to the age of _____.
 Still living Deceased

Upon the completion of your first visit, you will receive a Chiropractic Report to discuss the different types of Active Life Plans that are available to you. Active Life Plans are designed to get you feeling better quickly and to help you and your family be as healthy as possible. Please review the Active Life Plan Explanations prior to your Chiropractic Report so you can choose the level of participation that supports you in reaching all of your health goals.

As a result of my chiropractic care, I would like to (Please check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Feel better quickly | <input type="checkbox"/> Live a healthier lifestyle |
| <input type="checkbox"/> Have a healthier spine and nervous system | |

Signature

Date