HATBORO FAMILY WELLNESS HEALTH HISTORY FORM

Please fill out this form as completely and accurately as possible. **Fax (215) 394-5428 OR scan and email (drtara@hatborowellness.com) your forms** to the office and bring your originals with you to your first visit.

Today's Date____________________

PERSONAL DATA

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 ____

Emergency contact _______________________________________ Relationship ___________________________

Marital Status ❑ S ❑ M ❑ D ❑ W Spouse/Partner ____

Names and Ages of Children ____

Whom may we thank for referring you to our office? ____

REASON FOR SEEKING CHIROPRACTIC CARE

What concerns do you feel Hatboro Family Wellness can address for you?

____

How are these concerns affecting your quality of life? (Please check all that are applicable to you)

❑Work / School ❑Household ❑Standing ❑Sleep
❑Household duties ❑Caring for children ❑Sitting ❑Love Life
❑Exercise/sports ❑Recreational Activities ❑Energy ❑Other

HEALTH CARE PRACTITIONER HISTORY

Have you ever received Chiropractic care? ❑Y ❑ N Name of D.C.__________________________________

How long under care? _____days/ wks/ mos/ yrs Date of last visit: _________Why stopped? __________________

Have you consulted or do you regularly consult any of the following providers? (check all that apply)

❑ Medical Physician ❑ Naturopath ❑ Acupuncturist ❑ Homeopath
❑ Massage Therapist ❑ Psychotherapist ❑ Energy Healer ❑ Other

Reason why: ____

Name/Address of Medical Doctor: ____

Names(s) of other providers indicated: ____

FOR WOMAN

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

If pregnant, Due Date: ____________ Name of OBGYN or Midwife ____

Where will you be birthing your baby? ❑ Hospital ❑ Home ❑ Birthing Center ❑ Other__________________

Check any of the following related to your pregnancy, if applicable:

❑ Morning Sickness ❑ Reflux/heartburn ❑ Abnormal bleeding ❑ Anemia ❑ Diabetes

REVIEW OF SYSTEMS

Circle ☐ current symptoms AND/OR ☒ check ALL PAST symptoms. (Indicate both if applicable)

Nervous System: ☐**I DENY all symptoms listed below**

☐ Headache/Migraine ☐ Dizziness/Vertigo ☐ Anxiety/Depression ☐ Epilepsy ☐ Fainting
☐ Multiple Sclerosis ☐ Paralysis/Weakness ☐ Numb/Tingling ☐ Seizures ☐ Insomnia
☐ Concussion

Muscles & Joints: ☐**I DENY all symptoms listed below**

☐ Back Problems ☐ Shoulder Problems ☐ Hip Problems ☐ Neck Pain/Stiff ☐ Elbow Problems
☐ Knee Problems ☐ Painful/Stiff Joints ☐ Wrist Problem ☐ Ankle/Foot Problem ☐ Osteoarthritis
☐ TMJ Problems ☐ Spine Fracture ☐ Rheumatoid Arthritis ☐ Scoliosis ☐ Hernia

Respiratory: ☐**I DENY all symptoms listed below**

☐ Asthma ☐ Wheezing ☐ Chronic Cough ☐ Shortness of Breath ☐ Emphysema
☐ Cough with Blood ☐ Pleurisy ☐ Pneumonia ☐ Tuberculosis

EENT, Skin, Allergies: ☐**I DENY all symptoms listed below**

☐ Glasses or Contacts ☐ Loss of hearing ☐ Sinus Problems ☐ Speech difficulty ☐ Ear pain/Ringing
☐ Frequent Colds ☐ Sore Throats ☐ Ear infection ☐ Eczema ☐ Hoarseness
☐ Seasonal Allergies ☐ Hives/Rash ☐ Swallowing Difficulty ☐ Medication Allergy ☐ Skin growth
☐ Tonsillitis ☐ Food Allergy

G-I / Endocrine: ☐**I DENY all symptoms listed below**

☐ Acid reflux ☐ Frequent Diarrhea ☐ Diabetes ☐ Frequent Constipation ☐ Ulcer
☐ Nausea/ Vomiting ☐ Excessive Thirst ☐ Appendicitis ☐ Gall Bladder Trouble ☐ Hepatitis
☐ Black/Bloody Stool ☐ Poor Digestion ☐ Hemorrhoids ☐ Liver Trouble

Cardio-Vascular: ☐**I DENY all symptoms listed below**

☐ Chest pain ☐ High Blood Pressure ☐ Poor Circulation ☐ Thyroid Problems ☐ Bruising Easily
☐ Rapid/Racing Heart ☐ Stroke ☐ Ankle swelling ☐ Varicose Veins ☐ Anemia
☐ Heart Problems ☐ Irregular Heart Beat/Murmur

Genito-Urinary: ☐**I DENY all symptoms listed below**

☐ Blood in Urine ☐ Frequent Urination ☐ Bladder Infection ☐ Kidney Infection ☐ Painful Urination
☐ Prostate Trouble

General: ☐**I DENY all symptoms listed below**

☐ Chills/Sweats ☐ Weight Loss ☐ Weight Gain ☐ Cancer ☐ Fatigue
☐ Other not listed: ____

Females Only: ☐**I DENY all symptoms listed below**

☐ Backache w/ cycle ☐ Painful Periods Number of Pregnancies _________ Pill / IUD / Patch Use?
☐ Miscarriage ☐ Abnormal Discharge Number of Live Births _________ ☐Yes currently for __ yrs
☐ Infertility ☐ Hot Flashes ☐Yes (in past for __ yrs)
☐ Irregular Cycle ☐ Menopausal Symptoms ☐Never

FAMILY HISTORY

Please note any health problems that are present in:

Mother's family: ☐Heart Disease ☐High BP ☐Cancer ☐Stroke ☐Diabetes ☐Anxiety/Depression
Father's family: ☐Heart Disease ☐High BP ☐Cancer ☐Stroke ☐Diabetes ☐Anxiety/Depression
Siblings: ☐Heart Disease ☐High BP ☐Cancer ☐Stroke ☐Diabetes ☐Anxiety/Depression

List any other diseases that "run in your family" ____

HEALTH, WELLNESS AND CHIROPRACTIC CARE

The primary system in the body which coordinates health is the CENTRAL NERVE SYSTEM. The vertebrae, (bones of the spinal column) surround and protect the delicate NERVE SYSTEM. Chiropractors are specialists trained in "early detection" of injury to the SPINE & NERVE SYSTEM.

The information below will help us to see the types of PHYSICAL, EMOTIONAL & CHEMICAL stresses you have been subjected to and ***how they may relate to your present spinal, nerve and* health *status.***

PHYSICAL STRESS: BIRTH AND INFANCY

The birth process can traumatize a baby's spine and cause damage to the spine & nerve system.
Please indicate where and how you were birthed.

❑ Hospital ❑ Natural ❑ Cord around neck ❑ Cesarean section ❑ Forceps ❑ Unknown
❑ Breech ❑ Home ❑ Prolonged labor ❑ Drug induced labor ❑ Suction

PHYSICAL STRESS: CHILDHOOD THROUGH ADULT

The minor & often ignored repetitive physical traumas that we have endured are often too numerous to list. Please list the major traumas that you remember from your childhood up to the present.

Have you had any **accidents or injuries in your life** related to any of the following? (check all that apply)

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

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

____

____

Have you ever **hurt/injured your** spine, head, neck, ribs, chest, upper or lower back, pelvis or hips? ❑ Y ❑ N

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

____

____

Have you ever **hurt, broken, fractured or sprained** any bones or joints? ❑ Y ❑ N

If yes, list ***body parts injured and dates:***

____

____

Have you ever been hospitalized? ❑ Y ❑ N

If yes, ***state reason and dates:*** ______________________________

____

Have you ever had surgery? ❑ Y ❑ N

If yes, ***state reason and dates:*** ______________________________

____

EMOTIONAL STRESS

It is difficult to separate the emotional stress in our life from the physical response that often occurs.
Please indicate if you have EVER experienced <u>any</u> of the emotional stresses below:

❑ Childhood Trauma ❑ Loss of loved one ❑ Abuse ❑ None Known
❑ Financial ❑ Your divorce/separation ❑ Illness / Injury
❑ Work / School Stress ❑ Parental divorce ❑ Other

CHEMICAL STRESS

Chemical stress can occur when a substance, that is toxic to the body, is breathed, injected, taken by mouth, or placed on the skin (e.g.: food allergies, drug reactions, exposure to chemicals in the air, etc.) The following will reveal exposures you may have had.

Were you **vaccinated?** ❑ Y ❑ N If yes, did you have a **reaction**? ❑ Y ❑ N

Have you been **exposed to** any of the following on a regular basis, (past or present)?

❑ Toxic chemicals ❑ Radiation ❑ Second hand smoke ❑ Drug therapy ❑ Chemotherapy ❑ Other

If yes, please list:____

Do you have **allergies** to any foods? ❑ Y ❑ N **If yes, please list:** ______________________________

____

Do you **consume** any of the following presently?

❑ Coffee/caffeine ❑ Alcohol ❑ Tobacco ❑ Over the counter drugs ❑ Prescribed drugs

____cups/day ____drinks/week _____packs/day

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

____

____

Note: It is imperative that you list all medications as they may have an influence on your care.

QUALITY OF LIFE

How do you rate your **physical health**?	❑ Excellent	❑ Good	❑ Fair	❑ Poor
How do you rate your **emotional / mental health**?	❑ Excellent	❑ Good	❑ Fair	❑ Poor
How do you rate your **sleep quality**?	❑ Excellent	❑ Good	❑ Fair	❑ Poor
How do you rate your **"overall quality of life"**?	❑ Excellent	❑ Good	❑ Fair	❑ Poor
How would you rate your **stress levels**?	❑ Low	❑ Moderate	❑ High	

List **hobbies and activities** you enjoy: ____

Do you **exercise** regularly? If yes, how often? ____

Do you take **supplements**? If yes, please list:____

Do you follow a **special dietary regime**? Describe ____

____

EXPECTATIONS FROM CHIROPRACTIC CARE

I would like to have the following benefit(s) from **Chiropractic Care**: (Check all that apply)

❒ Relief of a symptom or problem

❒ Prevention of a symptom or problem

❒ Healthier spine and nerve system

❒ Optimal physical health and nerve system function

❒ Other ____

CHIROPRACTIC CLINICAL OBJECTIVE

Physical, Emotional and Chemical STRESSES, common to our contemporary lifestyles, can result in misalignment or abnormal movement of the spinal column causing stress to the nerve system. The result is a condition called **Vertebral Subluxation.** The Chiropractic Exam and Evaluation is specifically designed to detect Vertebral Subluxations in all phases of their progression.

PLEASE READ AND SIGN BELOW

The information I have provided, on this case history form, is true and accurate, to the best of my knowledge.

Patient / Guardian Signature: ____

FINANCIAL AGREEMENT

I understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment for all bills incurred at this office. I also understand that payment is expected at the time of service unless arrangements are made in advance. You will be informed of any fees associated with your visit prior to services being rendered. If you are unsure of the fee, please ask.

The following information will help you to understand how insurance can be utilized in our office and the details regarding your participation in the process.

We participate with insurance as an out-of-network provider. Insurance is a contract between the insured (patient) and the insurance company irrespective of you specific needs or care recommendations. Insurance companies, such as HMO's, PPO's and others, create their own guidelines, reimbursement rates and coverage. If chiropractic services are covered, the amount and type of reimbursement varies according to the policy that has been purchased by you or your employer.

In order to determine your insurance coverage, please obtain an **Insurance Verification Form,** from our staff or website, and contact your insurance company to determine the amount and extent of coverage. **You are responsible for contacting your insurance company to determine what they need in order for them to reimburse you directly.** If you have determined that your insurance will cover chiropractic care in our office, we can provide you with a periodic statement which includes charges, services provided, and diagnosis codes**. We will offer you additional assistance in the process as needed, just ask!** The insurance company is responsible to you, as the subscriber, not to us, the provider.

I understand that I am personally responsible for direct payment to Hatboro Family Wellness for all services received regardless of my insurance company's decision to pay. If I choose to submit for potential reimbursement, I understand and agree to obtain and complete all forms necessary for potential reimbursement of services which would be directly paid to me, the patient/guardian.

Patient Name Printed: ____

Patient / Guardian Signature: ____ Date: ____________________

Thank you for choosing Hatboro Family Wellness. We look forward to helping you.