Your Health History

Naas Chiropractic Clinic

Thank you for choosing Naas Chiropractic Clinic!

These questions are meant to help you think about injuries or traumas that occurred before you became an adult or began to take an active role in your health care. There are Yes and No checkboxes to the left of the question, and a space to leave comments to the right. If you do not know the answer to a question, you may leave it blank.

Patient Name:			Date:				
Yes	No		Comments				
1. \	1. Your Birth Process						
		Was the delivery long or difficult?					
		Forceps/Vacuum Extraction?					
		Caesarean?					
		Breach/Cephalic?					
		Mother given drugs during delivery?					
		Was labor induced?					
2.	Growth & De	evelopment					
		Were you breast fed?					
		Childhood Sicknesses?					
		Accidents?					
		Surgery?					
		Drugs?					
		Were you picked on by siblings?					
		Child Abuse (Spanking, Pulled Ear, Other)					
		Chair pulled out when sat down?					
		Did you fall down the stairs?					
		Were you yanked by your arm?					
		Did you have other traumas? What / When?					
_3.0	Current						
Ш		Diet (Do you consistently eat healthy foods?)					
Щ		Have you been in any accidents?					
Ц		Teeth Problems?					
\Box		Eye Problems?					
\square		Hearing Problems?					
닏		Sleeping habits (nightmares, quality, hrs/night?)					
\sqcup	\sqcup	Did/do you have occupational stress?					
닏	\vdash	Physical Stress?					
\square	\square	Mental Stress?					
\vdash	\sqcup	Hobbies/Sports Injuries?					
\Box		Sleeping posture: Side Stomach Back					

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Symptoms & III Health

These questions are about what is currently going on with your health, including what has brought to seek chiropractic care.

Present Complaint (Be Brief):							
Pain or Problem Started On:							
Pains are: Sharp Dull Constant Intermittent							
What activities aggravate your condition/pain?							
What activities lessen your condition/pain?							
Is the condition worse during certain times of the day?							
Is this condition interfering with work? Yes No							
Sleep? Yes No Routine? Yes No Other?							
Is this condition getting progressively worse?							
Other doctors seen for this condition:							
Any home remedies?							
Other Symptoms:							
Tension Irritability	Sleeping Pr	s Diz	ck Pain Nervousness ziness Face Flushed at Sensitivity Buzzing In Ears				
Loss of Memory Numbness	in Toes	Nur Nur	mbness in Fingers				
☐ Ears Ring ☐ Fever	☐ Fainting	Los	s of Smell Loss of Balance				
Loss of Taste Cold Sweat	ts Constipatio	on 🗌 Pin	s & Needles in Arms				
☐ Diarrhea ☐ Feet Cold	Stomach U	pset 🗌 Har	nds Cold 🔲 Pins & Needles in Legs				
lave you been under drug and medical care?							
s there a family history of:							
Maternal Grandmother							
Heart Disease Arthritis	Cancer	Diabetes	Other:				
Maternal Grandfather							
Heart Disease Arthritis	Cancer	Diabetes	Other:				
Mother:							
Heart Disease Arthritis	Cancer	☐ Diabetes	Other:				
Paternal Grandmother:							
Heart Disease Arthritis	Cancer	Diabetes	Other:				
Paternal Grandfather:							
Heart Disease Arthritis	Cancer	☐ Diabetes	Other:				
Tather:							
Heart Disease Arthritis	☐ Cancer	☐ Diabetes	Other:				