Rustici & Associates Chiropractic, P.C.

Patient Name: ______________________________ Date: ______________

Medical History

1. ***Was Your Birth Traumatic?***

Long/Difficult Delivery	□ Yes	□ No	Chiropractor's Notes: ______________
Forceps	□ Yes	□ No	Chiropractor's Notes: ______________
Breach/cephalic	□ Yes	□ No	Chiropractor's Notes: ______________
Induces labor	□ Yes	□ No	Chiropractor's Notes: ______________

2. ***Growth, Development & Current Health Habits? At any time have you…***

Fell out of bed	□ Yes	□ No	Chiropractor's Notes: ______________
Banged your head	□ Yes	□ No	Chiropractor's Notes: ______________
Had any accidents	□ Yes	□ No	Chiropractor's Notes: ______________
Fell while learning to walk	□ Yes	□ No	Chiropractor's Notes: ______________
Spanked	□ Yes	□ No	Chiropractor's Notes: ______________
Pulled by ear/chin	□ Yes	□ No	Chiropractor's Notes: ______________
Chair pulled out when sitting	□ Yes	□ No	Chiropractor's Notes: ______________
Fell down the stairs	□ Yes	□ No	Chiropractor's Notes: ______________
Pulled by your arm	□ Yes	□ No	Chiropractor's Notes: ______________
Have occasional stress	□ Yes	□ No	Chiropractor's Notes: ______________
Have physical stress	□ Yes	□ No	Chiropractor's Notes: ______________
Have mental stress	□ Yes	□ No	Chiropractor's Notes: ______________

3. ***What is your Sleeping Posture?***

□ Side □ Stomach □ Back Chiropractor's Notes: ______________

Have you seen a Chiropractor before? □ Yes □ No

Outcome of Care: ______________________________

Social History

Please indicate beside each activity whether you engage in it:

O = Often S = Sometime N = Never

Vigorous Exercise	________	Chiropractor's Notes: ______________
Moderate Exercise	________	Chiropractor's Notes: ______________
Daily Exercise	________	Chiropractor's Notes: ______________
Alcohol Use	________	Chiropractor's Notes: ______________
Drug Use	________	Chiropractor's Notes: ______________
Tobacco Use	________	Chiropractor's Notes: ______________
Caffeine	________	Chiropractor's Notes: ______________
High Stress Activity	________	Chiropractor's Notes: ______________
Family Pressures	________	Chiropractor's Notes: ______________
Other – Specify*	________	Chiropractor's Notes: ______________

What are your favorite hobbies or activities you do now? ______________________________

Are your current problems affecting these activities? ______________________________

What activities are you looking forward to in your retirement? ______________________________

Who would you like to be doing these with? ______________________________

Family History

Please use checkmark, check all that apply.

CONDITIONS:	PATIENT	SPOUSE	CHILDREN	FATHER	MOTHER	BROTHER(S)	SISTER(S)
Age							
Living or Deceased							
Arthritis							
Artificial Bone/Joint							
Asthma / Hay Fever							
Breathing Problems							
Blood Disorders							
Cancer							
Carpal Tunnel							
Chest Pain/Tightness							
Constipation							
Depression							
Diabetes I/II							
Dizziness							
Fatigue							
Feet Cold							
Frequent Colds							
Hands Cold							
Headaches							
Heart Trouble							
High Blood Pressure							
Hysterectomy							
Indigestion							
Irritability							
Jaw Pain							
Kidney Trouble							
Lights Bother Eyes							
Loss of Balance							
Loss of Memory							
Loss of Smell							
Loss of Taste							
Menstrual Problems							
Migraine							
Nervousness							
Numbness							
Ringing in Ears							
Scoliosis							
Shoulder/Arm Pain							
Sinus Trouble							
Sleeping Problems							
Stomach Trouble							
Thyroid							
Weight Gain							
Weight Loss							
Other – Specify *							

* Other: ____

On a scale of 1-10 (10 being the most and 1 being the least)

______ How committed are you to reaching your maximum health potential?

______ How important is it to you for your family to realize their optimum health potential?

______ How committed are you to maximizing your spinal stability?