Mt Peak Chiropractic

895 Manns Hill Road
Littleton, H.N. 03561
603-444-4881

Name_____ Date_____

Address_____ Home Phone_____

City_____State_____Zip_____ Cell Phone_____

Email_____ Business Phone_____

Date of Birth_____Age_____F__M__ Marital Status_____#children__

Social Security #_____ Occupation_____

Insurance_____

How did you hear about our office?_____

Your Personal History:

Have you ever had your spine or nervous system examined before?_____
If yes, when, and by whom?_____
Have you received chiropractic adjustments by a Doctor of Chiropractic?_____
If yes, when was your last visit?_____
How long were you receiving chiropractic adjustments?_____
How often did you go?_____If you stopped, why did you stop going?_____
Do you know what type of adjustments the chiropractor performed, or what technique was used?_____
Does your immediate family receive chiropractic care?_____
What do you hope to receive at our office?_____

Pain Assessment:

Constant___ Daily____ Intermittent____ With Activity____ Occasional____ Other____
Severity of complaint or level of pain at onset:

(Less Intense) 1 2 3 4 5 6 7 8 9 10 (More Intense)

Severity of complaint or level of pain presently:

(Less Intense) 1 2 3 4 5 6 7 8 9 10 (More Intense)

Site of pain_____

Description of pain (Stab,throb,ache…)_____
What makes it feel worse?_____
What makes it feel better?_____

How and when did it start?_____

How has the frequency or intensity changed?_____

What treatment have you done?_____

Is there anything else that may help me understand you better?_____

The practice of chiropractic is based upon the location and adjustment of subluxations. Subluxations are caused by any stress that your body is unable to adapt to and use. These stresses may be physical, chemical, or emotional in nature.

Physical Stress, Birth History:

Was your mother outwardly ill prior to her pregnancy with you? Yes__No___
Did your mother have a difficult pregnancy with you? Yes__No___
Did your mother have any falls, accidents or physical injuries during pregnancy? Yes__ No__
My birth was at home____ In a birthing center____ In the hospital____
Was your delivery traumatic? Yes__ No__
Check any that may apply to your delivery: Drug induced____ Forceps or Suction____ C-section____
Cord around neck____ Breech____ Prolonged____.

General Physical Trauma:

Have you taken any falls during your life? (Down stairs, on ice….) Yes__ No__
If yes, when and how?_____
Have you ever used crutches, a walker, or cane? Yes__ No__
If yes, when and why?_____
Have you ever broken any bones? Yes__ No__
If yes, when and how?_____
Have you ever had any impacts, falls or jolts that you feel may have injured your spine? Yes__ No__
If yes, when and how?_____
Have you had any extensive dental work performed or Orthodontic work? Yes__ No__
During the day I: Sit__ Stand__ Walk__ Desk work__ Phone work__ Drive__
During the day I: Do mechanical work__ Heavy lifting__ Other_____

Sports and Leisure:

I exercise: Daily___ weekly___ Monthly___
What activities/sports did you participate in?_____
What activities/sports do you participate in presently?_____
Have you been hurt in any of these activities?_____
Do you wear? Contacts__ Bifocals__ Trifocals__ Glasses__

Automobile Accidents:

Have you, ever as a passenger, even if you do not think you were hurt, been involved in a vehicle collision/near collision (car, motorcycle, snowmobile, plane…)? Please list approximate dates and severity (mild, moderate, extreme). _____
_____

Medical Treatments:

Have you ever been hospitalized? Yes__ No__
If yes, when and why?_____
Have you ever had surgery? When?_____ Yes__ No__
Are you presently or in the past had chemotherapy or radiation therapy? _____
If yes, when and why?_____
Do you still have all your body parts?_____
Have you ever had any of the following? Spinal tap__ Spinal injections__ Physical therapy__
Neck collar__ Spinal brace__ Traction__ Heel lifts__ X-rays__ Acupuncture__ Transfusion__

Chemical Stress, Birth History:

Was your mother taking any medications/drugs prior or during her pregnancy with you? Yes__ No__
Alcohol___ Smoking___ Medications/drugs_____
Was her labor chemically induced or altered? Yes__ No__
Was your mother: Conscious__ Semiconscious__ Unconscious__ during your delivery?
Were you: Nursed__ Bottle fed mothers milk__ Nursed and bottle fed___ Formula fed___?

General Chemical Trauma:

Are you presently taking any medications (prescription or over-the-counter)? Yes__ No__

List medications:	To Treat:	Duration/For how long?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Were you previously taking and medications regularly?_____
Are you presently taking any vitamins, herbal supplementation? Yes__ No__
If yes, which ones and why?_____

Please circle any dietary selection that is appropriate for you, and grade according to the following scale.

D – daily
FD – few times per day
W – weekly
FW – few times per week
M - monthly
FM – few times per month
O – do not consume

Alcohol _____	Eggs_____	Beef_____
Coffee/ Tea_____	Cooked, canned veggies_____	Poultry_____
Tobacco _____	Raw/Fresh veggies_____	Fish_____
Artificial Sweetner _____	Fruit_____	Seafood_____
Soda_____	Whole grains_____	Weight control diet_____
Diet/fat free Food _____	Dairy, cheese_____	Fasting_____
Refined sugar _____	Fried foods_____	Organic foods_____

The type of diet I usually follow is classified as:_____

Emotional Stress:

With each of the following stresses, please check either "**P**" for past or "**C**" for current, if applicable.

	Mild	**Moderate**	**Extreme**		**Mild**	**Moderate**	**Extreme**
	P/C	P/C	P/C		P/C	P/C	P/C
Childhood Stress	__/__	__/__	__/__	Work stress	__/__	__/__	__/__
Play/recreation stress	__/___	__/__	__/__	Stress of commuting	__/__	__/__	__/__
Family stress	__/__	__/__	__/__	Loss of loved one	__/__	__/__	__/__
Personal stress	__/__	__/__	__/__	Change in life style	__/__	__/__	__/__
Stress from being sick	__/__	__/__	__/__	Abuse	__/__	__/__	__/__

How would your grade your Physical health? Good__ Fair__ Poor__ Getting better__ Getting worse__?
How would you grade your emotional health? Good__ Fair__ Poor__ Getting better__ Getting worse__?

Is there anything else which may help to better understand you which has not been asked?

_____

_____