

Mt Peak Chiropractic

101 Cottage St. 7A
Littleton, H.N. 03561
603-616-9487

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?
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_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

M - monthly

FD – few times per day

FM – few times per month

W – weekly

O – do not consume

FW – few times per week

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 you 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?
