

# HALL CHIROPRACTIC

Main Rd., Feather Hill  
Southold, NY 11971

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_ **DOB:** \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ E-mail Address \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone & Extension : \_\_\_\_\_

Social Security #: \_\_\_\_\_ Marital Status: \_\_\_\_\_ # of Children: \_\_\_\_\_

Insurance company: \_\_\_\_\_ Primary Insured: \_\_\_\_\_

DOB of Insured: \_\_\_\_\_ Relationship to Insured: \_\_\_\_\_ SSN of Insured: \_\_\_\_\_

Address of Insured: \_\_\_\_\_

Is this a work-related injury?  Yes  No *If yes, please inform receptionist*

Is this an automobile-related injury?  Yes  No *If yes, please inform receptionist*

How did you hear about our office? \_\_\_\_\_

Have you ever received chiropractic spinal adjustments by a chiropractor?  Yes  No

If yes, when and by whom? \_\_\_\_\_

What do you hope to receive from chiropractic and this office? \_\_\_\_\_

**Please check  the appropriate level for each area or system of the body:**

<i>Function, Flexibility, Ease</i>	<i>Poor</i>	<i>Fair</i>	<i>Good</i>	<i>Excellent</i>
Sight				
Smell				
Ears, hearing				
Head and neck				
Back				
Shoulders, elbows, wrists, hands				
Hips				
Knees				
Ankles, feet				
Breathing (sinuses, bronchi, lungs)				
Digestion (stomach, intestines)				
Bowels (elimination)				
Circulation				
Immune system (strength, hardiness, resiliency)				
Clarity of thought				
Balance of emotions				
Happiness, joy				
Overall energy level				
Sleep				

Did your mother have a difficult pregnancy with you?  Yes  No \_\_\_\_\_

Did she have any illnesses while pregnant with you?  Yes  No \_\_\_\_\_

Did she fall during her pregnancy?  Yes  No \_\_\_\_\_

Did she experience any trauma during her pregnancy?  Yes  No \_\_\_\_\_

Did she take any drugs during her pregnancy?  Yes  No \_\_\_\_\_

<i>Have you ever:</i>	Yes	No	If Yes, date(s) & Explanation
Been knocked unconscious?			
Broken any bones?			
Had any sports injuries?			
Sprains or strains?			
Work-related injuries?			
Motor vehicle accidents?			
Surgery?			
Traction?			
Heel lift?			
Physical therapy?			
Neck collar?			
Cast?			
X-ray treatments?			
Chemotherapy?			

*Do you regularly (circle):*

Exercise? Run? Yoga? Meditate? Dance? Read for prolonged periods? Watch TV for prolonged periods?  
Play a musical instrument?

Please list any drugs (prescription or non-prescription) you take regularly: \_\_\_\_\_

\_\_\_\_\_

Are you currently being treated medically for any conditions?  Yes  No

If yes, please explain: \_\_\_\_\_

Name of Medical Doctor: \_\_\_\_\_

**Emotional and chemical stresses can be particularly detrimental to spinal health.**

*Please circle any of the following that apply to you:*

- |                     |                     |                              |   |
|---------------------|---------------------|------------------------------|---|
| Childhood stress    | Family stress       | Personal relationship stress | Stress of being sick  |
| Work-related stress | Stress of commuting | Loss of loved one            | Stress of moving  |
| Change in job       | Change in lifestyle | Abuse                        | Chemical related stresses<br>(paints, chemicals, fumes,<br>dusts, powders, smoking) |

Please grade your physical health (circle): Excellent Good Fair Poor Getting better Getting worse

Your emotional health: Excellent Good Fair Poor Getting better Getting worse

If you consider yourself ill, why do you feel you are ill? \_\_\_\_\_

\_\_\_\_\_

If you consider yourself well, why do you feel you are well? \_\_\_\_\_

\_\_\_\_\_

On a scale from 1-10, how committed are you to genuine health? \_\_\_\_\_

Thank you.