New Patient Case History

Date / /

Personal Data

Name ______________________ SS#______________________ Birthday / /

Address ______________________ Home # ______________________ Work # ______________________

City ______________________ State _____ Zip ______________ Cell # ______________________

Marital Status: S M D W Partnered Spouse/Partner's Name ______________ Age of Children __________

Email ______________________ Occupation ______________________ Employer ______________________

Employer Address ______________________ Who referred you to us? ______________________

Health History

Have you been under Chiropractic care before? ________ When? ____________ How long? ____________

Chiropractor's name ______________________ Why did you discontinue care? ______________________

Reasons for consulting this practice:

Please check any of the following statements that describe(s) your current goals for your health and well being:

- ❑ I am only concerned about relief of a particular symptom.
- ❑ I am concerned about relief of a particular symptom, and preventing its return.
- ❑ I want to perform at the highest capacity.

CAUSE

The human body is designed to be healthy. The primary system in the body which coordinates health is the nervous system. The healthy function of every cell, every system, and every organ is dependent upon the integrity of the nervous system. The bones of the skull and vertebrae of the spine house and protect the central nervous system.

From the birth process until the present, events have occurred in your life which may have caused interference and damage to this delicate system. Physical, emotional, and chemical stresses common to our contemporary lifestyles can result in misalignment and damage to the spinal column. This interference is called the Vertebral Subluxation Complex.

This form will help reveal the causes of Vertebral Subluxation which interfere with the optimal function of your nervous system and therefore impair your inborn health and wellbeing.

Please tell us about any stress you know of that was associated with your birth (your entry into the world, not your child's) (i.e. difficult delivery, drugs during labor, complications, etc). Please be complete.

Please tell us about any stress associated with your childhood (i.e., falls, broken bones, contact sports, frequent or serious illness, medications, divorce, loss). Please be complete.

Please tell us about any accidents, physical injuries, or traumas of significance that occurred as you grew.

Village Family
CHIROPRACTIC
617-566-2001

Please continue on the back

Stress can take three forms in your body – Physical, Chemical and Emotional. Please tell us about any adult or more recent stress or trauma (i.e. work stress, auto injuries, other traumas, loss of a loved one, divorce, large amounts of sugar or artificial sweeteners, surgeries, illnesses, medications). Please be complete.

Please describe the physical aspects of your daily life. (i.e. lifting, sitting, talking on the phone, typing, computer time, tv).

I currently:

- ❑ smoke
- ❑ drink alcohol ❑ 1-3 glasses /wk ❑ 4-7/week
- ❑ drink coffee or tea ____ cups/day
- ❑ exercise ❑ 1-2x/wk ❑ 3-5x/wk ❑ 7+x/wk
- ❑ eat a fast food meal ❑ 1-3/wk ❑ 4+/wk

On a scale of 1-10, with 10 being optimum, how would you rate your current health? ________________________

If your health does not rate a 10, how likely is it that it will reach a 10 in the foreseeable future? ___________________

What other health care are you receiving?

What are you currently doing to either maintain or improve your health? You may want to include mental/spiritual as well as physical and chemical (diet) health measures.

(Women only) Are you, or might you be pregnant? Y N Date of last menstrual period: ____________________

I affirm that the information in this case history is correct to the best of my knowledge. I also understand that I am ultimately responsible for charges on my account with Village Family Chiropractic regardless of my insurance arrangements.

____

signature

I understand that all services are to be paid in full at the time of service, unless other arrangements have been made and agreed upon in writing. We accept payment by cash, check, and credit card.

____

signature

617-566-2001

Smile! Life's about to improve! Congrats on taking this step to care for yourself!

Welcome to the practice! ***Dr. Lisa Geiger***

Name:______________________________ **Date:** __________________

Please note any **current or former** health problems of you or a family member.

Condition	**Self** Age ( )	**Father** Age ( )	**Mother** Age ( )	**Spouse** Age ( )	**Brother(s)** Age ( )	**Sister(s)** Age ( )	**Children** Age ( )
Allergies							
Anxiety/Panic							
Arthritis							
Asthma							
Autism/PDD/ADHD							
Back Trouble							
Blood Pressure H/L							
Cancer							
Carpal Tunnel Synd.							
Constipation/Diarrhea							
Constant Colds							
Diabetes							
Disc Problems							
Ear Infections							
Emphysema							
Epilepsy							
Headaches/Migraine							
Heart Trouble							
Kidney Trouble							
Liver Trouble							
Neuritis							
Pinched Nerve							
Sciatica							
Scoliosis							
Sinus Trouble							
Sleep Problems							
Tinnitus							
Torticollis/Wry Neck							
Urinary Tract Inf.							
Other							
Other							

List any of the above family members that are deceased. Please include their age at death and cause:

____

____

The above information is accurate and complete, to my knowledge at this time.

____ ______________________

Patient Signature ***Date***