GARDINER FAMILY CHIROPRACTIC
PATIENT HEALTH HISTORY Side 2 of 2

Full Name:____Date:_______________

Reason **Hospitalizations**	Year

This section for women only

Are you currently pregnant? Y / N
If yes, due date _______________
Number of pregnancies __________
Number of children ______________
Ages ________________________
Do you take birth control pills? Y / N
If yes, brand ___________________________
Are you taking Hormone/estrogen replacement?
Y / N If yes, how long? _______________

X-rays/Imaging Studies in Past 5 Years	
Type	Where performed

Past History of Trauma (accidents, falls, etc.)	Year

For the safety of our staff, please answer the following question honestly. Your answer will be kept in strictest confidence.

☐ **No** ☐ **Yes** **Do you have any illnesses which may be transmitted through bodily fluids and/or skin contact? (i.e. HIV/AIDS, Hepatitis, Herpes, etc.?)**

If you answered Yes: Please discuss the nature of the illness with the doctor so that our staff may take appropriate personal protection measures.

If you answered No: If at any time you contract such an illness, please inform the doctor as soon as possible so that our staff may take appropriate personal protection measures.

YOUR EXPERIENCE WITH CHIROPRACTIC

Have you been adjusted by a Chiropractor before? Y / N

Reason for those visits? _________________________________ Doctor's Name ___________________________

Approximate date of last visit ____________________________

Has any adult in your family seen a Chiropractor? Y / N

Has any child in your family seen a Chiropractor? Y / N

People see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others for correction of whatever is malfunctioning in their bodies. Your Doctor will weigh your needs and desires when recommending your treatment program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

___**Comprehensive care** – Bring whatever is malfunctioning in the body to the highest rate of health possible with Chiropractic care

___**Corrective care** – Correcting and relieving the cause of the problem as well as the symptoms

___**Relief care** – Symptomatic relief of pain or discomfort.

___I want the doctor to select the type of care appropriate for my condition

Patient Signature____ Date__________________

PLEASE COMPLETE BOTH SIDES OF THIS FORM

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