Precision Spinal Care, PLLC

Dr. Lisa S. Olszewski
Upper Cervical Chiropractor

1600 Commerce Park Drive
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Personal and Family Health History

Name ____

Sex: Male _____ Female ____ Date of Birth________

Address ______________________________________

City ____________________ State ____ Zip ________

Phone: (H) _______________ (W) ________________

(Cell)_______________

If needed to be contacted during day time

hours use this number_______________

In case of an emergency contact:_________________

Emergency contact number______________________

Date:____

Occupation ____________________________________

Employer ______________________________________

Employed Full time( ) Part time ( )

Retired ( ) Date of Retirement__________

Marital Status S M D W

Spouse's Name _______________________________

Spouse's Occupation ____________________________

Referred By ___________________________________

Previous Chiropractic Care? _______________________

Approx number of adjustments over your lifetime______

Number of Children and Ages ***Previous Chiropractic Care?***

Name _____________________________ Age _____ Yes___ No___ Reason ______________________________

Name _____________________________ Age _____ Yes___ No___ Reason ______________________________

Name _____________________________ Age _____ Yes___ No___ Reason ______________________________

Name _____________________________ Age _____ Yes___ No___ Reason ______________________________

You deserve to be healthy. Life is a miracle and so are you. When you were created, you were given all the blue-prints, intelligence, tools, and systems to live an active healthy life. Unfortunately, your health can be interfered with through accidents and challenges that cause a disruption to your health expression. Through your examination and through your lifetime involvement in chiropractic care, we will work to remove these interferences to your natural health expression so that you can live the quality of life you deserve.

Circle all that Apply	***Patient***	***Spouse***	***Child#1***	***Child#2***	***Child #3***	***Chiropractor's Comments***
1. Was Your Birth Traumatic?						
Long Delivery?	Y	Y	Y	Y	Y	________________
Difficult Delivery?	Y	Y	Y	Y	Y	________________
Forceps?	Y	Y	Y	Y	Y	________________
Caesarian?	Y	Y	Y	Y	Y	________________
Breach/cephalic?	Y	Y	Y	Y	Y	________________
Home birth?	Y	Y	Y	Y	Y	________________
Mother given drugs during delivery?	Y	Y	Y	Y	Y	________________
Induced Labor?	Y	Y	Y	Y	Y	________________
2. Growth and Development						
Did you ever once...						
Learn to care for your spine?	Y	Y	Y	Y	Y	________________
Fall out of bed?	Y	Y	Y	Y	Y	________________
Bang your head?	Y	Y	Y	Y	Y	________________
Breastfeed?	Y	Y	Y	Y	Y	________________
Childhood sickness?	Y	Y	Y	Y	Y	________________

Have any Accidents?	Y	Y	Y	Y	Y	________________
Have Surgery?	Y	Y	Y	Y	Y	________________
Have Ear Infections	Y	Y	Y	Y	Y	________________
Take medication?	Y	Y	Y	Y	Y	________________
Fall while learning to walk?	Y	Y	Y	Y	Y	________________
Chair pulled out when sitting?	Y	Y	Y	Y	Y	________________
Fall down the stairs?	Y	Y	Y	Y	Y	________________
Pulled by your arm?	Y	Y	Y	Y	Y	________________
Experience other traumas?	Y	Y	Y	Y	Y	________________

3. Current Health Habits

Did/do you...

Smoke or use other tobacco products?	Y	Y	Y	Y	Y	________________
Drink?	Y	Y	Y	Y	Y	________________
Diet (do you eat healthy foods?)	Y	Y	Y	Y	Y	________________
Have you been in accidents?	Y	Y	Y	Y	Y	________________
Have you had surgery and organs replaced/removed?	Y	Y	Y	Y	Y	________________
Drugs? (Prescriptive or Non-Prescriptive)	Y	Y	Y	Y	Y	________________
Have Teeth Problems?	Y	Y	Y	Y	Y	________________
Have Eye Problems?	Y	Y	Y	Y	Y	________________
Have Hearing Problems?	Y	Y	Y	Y	Y	________________
Exercise regularly?	Y	Y	Y	Y	Y	________________
Have sleeping problems? (nightmares)?	Y	Y	Y	Y	Y	________________
Have occupational stress?	Y	Y	Y	Y	Y	________________
Have physical stress?	Y	Y	Y	Y	Y	________________
Have mental stress?	Y	Y	Y	Y	Y	________________
Have hobbies/sports injuries?	Y	Y	Y	Y	Y	________________
Sleeping posture – side–stomach–back	_____	_____	_____	_____	_____	________________

Current Health Condition

Present Complaint (be brief) Reason For Your Visit Today

Major ____

How long have you been living this way? ____

Pains are: ❒ Sharp ❒ Dull ❒ Constant ❒ Intermittent

What activities aggravate your condition/pain? ____________________________________

What activities lessen your condition/pain? ______________________________________

Is condition worse during certain times of the day? ________________________________

Is this condition interfering with work? ______ Sleep? ______ Family Life? _______ Social Life?_________

Ability to Exercise? _________ Hobbies?_______ Other? __________

Is this condition getting progressively worse? ____________________________________

Other Doctors seen for this condition ____

Any home remedies? ____

Other symptoms:

❒ Headaches
❒ Neck Pain
❒ Blurred Vision
❒ Sleeping Problems
❒ Back Pain
❒ Nervousness
❒ Tension
❒ Irritability
❒ Chest Pains
❒ Dizziness
❒ Face Flushed
❒ Neck Stiff
❒ Pins & Needles in Legs
❒ Pins & Needles in Arms
❒ Numbness in Fingers
❒ Numbness in Toes
❒ Shortness of Breath
❒ Fatigue
❒ Depression
❒ Light Bothers Eyes
❒ Loss of Memory
❒ Ears Ring
❒ Fever
❒ Fainting
❒ Cold Sweats
❒ Loss of Smell
❒ Loss of Taste
❒ Diarrhea
❒ Feet Cold
❒ Hands Cold
❒ Stomach Upset
❒ Constipation
❒ Loss of Balance
❒ Frequent Colds
❒ Loss of Energy

Are you under medical care? ____

Doctor"s Name:_________________________________Location:__________________________________

What medications are you taking and for how long;____

____

Have you had surgery? __________What/When?____

____

____

____

What side effects have you experienced from the drugs and surgery? ___________________________________

Is there a family history of:

	Heart Disease	Arthritis	Cancer	Diabetes	Other ______________
Father's Side	❒	❒	❒	❒	❒
Mother's Side	❒	❒	❒	❒	❒

What are your objectives from receiving and maintaining your spinal correction at Precision Spinal Care?

____

____

____

Are you willing to be an active participant in the improvement of your health?_____________________________

Name and address of the last health professional that put you on a wellness program:_______________________

As a result of my chiropractic care, I would like to

Please check all that apply

- ❒ Feel better quickly
- ❒ Have a healthier spine
- ❒ Have a healthier body by keeping my nerve system healthy
- ❒ Live a healthier lifestyle

_________________________________ Signature

_________________ Date

"The doctor of the future will give no medicine but will interest his patients in the care of the human frame, in diet, and in the cause and prevention of disease."

Thomas A. Edison

Rvsd8/06