Precision Spinal Care, PLLC

Dr. Lisa S. Olszewski
Upper Cervical Chiropractor

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Personal and Family Health History

Date: _____

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_____

Email_____

Previous Chiropractic Care? _____

Occupation _____

Employer _____

Employed Full time ( ) Part time ( )

Retired ( ) Date of Retirement_____

Marital Status S M D W

Spouse's Name _____

Spouse's Occupation _____

Have you been referred to our office by another physician? YES / NO If yes who? _____

If no, how did you hear about Dr. Olszewski?

_____

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	_____

Circle all that Apply	*Patient*	*Spouse*	*Child#1*	*Child#2*	*Child #3*	*Chiropractor's Comments*
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) or the reason for your visit today_____

_____

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 do daily chores?_____ Ability to Exercise? _____ Hobbies?_____ Other? _____

Is this condition getting progressively worse? _____

Other Doctors seen for this condition _____

Any home remedies? _____

Please continue on to page 3.

Other symptoms:

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

Are you under medical care? _____

Doctor's Name: _____Location:_____

Would you like Dr. Olszewski to share her findings and treatment plan with your doctor for coordination of care?

YES / NO If yes name(s) of doctor(s) and location of practice: _____

_____

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	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