Sandy Plains Chiropractic

2697 Sandy Plains Rd.
Marietta, Ga. 30066
(770) 971 – 1355
fax (770) 509 – 8559

Confidential Health Concern History: Personal Information:

Last Name: _____ First Name: _____Nickname_____

Address: _____ Home Phone: _____

City: _____ St: _____ Zip: _____ Cell Phone :_____

Date of Birth: _____ Social Security Number: _____-_____-_____

Occupation: _____ Employer: _____ Work Phone: _____

Family Physician: _____ Marital Status: M_____ S_____ D_____ W _____

Who may we thank for your referral to our office? _____

If you have children, what are their ages? _____

Email address: _____ May we send you a 1x/mo. office newsletter? __ Yes __ No

In-case-of-emergency, Contact : _____

Health Information:

What has brought you to our office and what are your objectives in consulting with us? _____
_____

What are your health goals once these objectives have been met? _____
_____

Who was the last doctor who created a health development plan for you? _____

Did you follow all the doctor's recommendations? __ Yes __ No

How long were you able to stay on the health development plan? _____

What were your results? _____

What other wellness professionals are currently part of your health care team?

___ Massage Therapist ___ Acupuncturist ___ Naturopath ___ Homeopath
___ Other _____

How many medical doctor's office visits did you and your family have last year?

___ None ___ Less than 5 ___ More than 5 ___ More than 10

Have you had previous Chiropractic care? ___ Yes ___ No This year? ___ Yes ___ No

Please list previous surgeries and dates: _____

Medications: ___ Pain Meds ___ Birth Control ___ Heart Meds ___ Cholesterol Meds ___ Other _____
_____

Lifestyle Information:

Do you exercise? ___ Yes ___ No If yes, how much and how often? _____

Do you smoke? ___ Yes ___ No If yes, how much? _____

Do you consume alcohol? ___ Yes ___ No If yes, how much and how often? _____

Do you drink water? ___ Yes ___ No If yes, how much per day? _____

Health History:

Please check all of the following health concerns that you have experienced, even if you do not think that your answers relate to your present health concern. (List specific conditions on back)

Allergies	__ Yes __ No	Heart Condition	__ Yes __ No
Anxiety	__ Yes __ No	Immune System Disorder	__ Yes __ No
Arthritis	__ Yes __ No	Infertility	__ Yes __ No
Asthma	__ Yes __ No	Kidney Disease	__ Yes __ No
Back Pain	__ Yes __ No	Menstrual Cramps	__ Yes __ No
Bladder Problems	__ Yes __ No	Mood Swings	__ Yes __ No
Cancer	__ Yes __ No	Neck Pain	__ Yes __ No
Circulatory Disorder	__ Yes __ No	Numbness/Tingling	__ Yes __ No
Depression	__ Yes __ No	Osteoporosis	__ Yes __ No
Diarrhea	__ Yes __ No	Sinus Trouble	__ Yes __ No
Digestive Problems	__ Yes __ No	Skin Conditions	__ Yes __ No
Dizziness	__ Yes __ No	Urinary Difficultly	__ Yes __ No
Headaches	__ Yes __ No	Vertigo	__ Yes __ No
Heartburn/Reflux	__ Yes __ No	Other: _____	__ Yes __ No

PHYSICAL STRESS:	**C**hild	**T**een	**A**dult	**N**one	Explain:
Birth Traumas (Forceps, Cesarean, breach, with drugs)	C	T	A	N	_____
Illness, Hospitalizations, or Surgeries	C	T	A	N	_____
Broken bones/sprains	C	T	A	N	_____
Slips/Falls	C	T	A	N	_____
Car Accidents	C	T	A	N	_____
Sports Injuries	C	T	A	N	_____
Physical Abuse	C	T	A	N	_____
Work Injuries	C	T	A	N	_____
Poor Posture	C	T	A	N	_____
Sitting on a wallet for years	C	T	A	N	_____
Sleeping Position – Stomach	C	T	A	N	_____
Extensive Computer Work/ phone work	C	T	A	N	_____
Carrying a heavy purse/book bag/child	C	T	A	N	_____
Repetitive lifting/bending	C	T	A	N	_____
Driving for many hours	C	T	A	N	_____
Continuous hours sitting/standing	C	T	A	N	_____
Shoveling/Painting/Gardening/Cleaning	C	T	A	N	_____

CHEMICAL STRESS:					
Smoker – Amount?	C	T	A	N	_____
Alcohol – Amount?	C	T	A	N	_____
Caffeine – Amount?	C	T	A	N	_____
Excessive Sugar / Artificial Sweeteners	C	T	A	N	_____
Prolonged use of Medications (antibiotics, inhalers...)	C	T	A	N	_____

EMOTIONAL STRESS:					
Relationships	C	T	A	N	_____
Career	C	T	A	N	_____
Children	C	T	A	N	_____
Fast-Paced Life	C	T	A	N	_____
Hold in Feelings	C	T	A	N	_____
Quick Tempered	C	T	A	N	_____
Verbal Abuse	C	T	A	N	_____
Perfectionist	C	T	A	N	_____
Procrastinator	C	T	A	N	_____
Loss of a Loved One	C	T	A	N	_____

Which best describes your reason for consulting our office?

___ I have a specific concern and require help only with this concern.

___ I want to ensure that my health concerns do not become an ongoing problem that will impact my future health.

___ I want to be healthier five years from now than I am today.