DR. CARMONA CHIROPRACTIC

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Today's Date_____

PERSONAL DATA

Name _____ Age _____ Date of Birth _____

Both Parent's names (if you are under 18)_____

Home Address _____ City _____ State _____ Zip _____

Home phone (____) _____ Business Phone (____) _____

Cell Phone (____) _____Carrier_____ SS#_____

E-mail address_____@ _____

Occupation _____ Employer _____

Marital Status ❑ S ❑ M ❑ D ❑ W ❑ L/W Spouse/Partner _____

Names and Ages of Children_____

Whom may we thank for referring you to our office? _____

REASON FOR SEEKING CHIROPRACTIC CARE

What concerns do you feel Carmona Chiropractic can address for you? _____

_____

Are these concerns affecting your quality of life? (Please circle all that apply)

Work:	Y	N	Driving:	Y	N	Sleep:	Y	N
School:	Y	N	Walking:	Y	N	Sitting:	Y	N
Exercise/sports:	Y	N	Eating:	Y	N	Love life:	Y	N

Explain:_____

_____

HEALTH CARE PRACTITIONER HISTORY

Have you ever received Chiropractic care? ❑Y ❑ N Name of D.C. _____

How long under care? ❑ _____days ❑_____weeks ❑_____months ❑_____ years

Date of last visit: _____ Why did you stop care?_____

Have you consulted or do you regularly consult any of the following providers? (check all that apply)

❑ Medical Physician ❑ Naturopath ❑ Acupuncturist ❑ Homeopath

❑ Massage Therapist ❑ Psychotherapist ❑ Energy Healer ❑ Dentist

Reason:_____

The primary system in the body which coordinates health is the NERVE SYSTEM.
The vertebrae (bones of the spinal column) surround and protect the delicate NERVE SYSTEM.
Injury to the SPINE and NERVE SYSTEM is a condition called VERTEBRAL SUBLUXATION.
VERTEBRAL SUBLUXATION results in nerve malfunction due to vertebral/spinal misalignment.

Vertebral Subluxations can have Physical, Emotional and Chemical causes and effects.

The information below will help us to see the types of PHYSICAL, EMOTIONAL & CHEMICAL stresses you have been subjected to in your life, how they may relate to your present spinal, nerve and health status and whether they may have caused Vertebral Subluxations to occur.

FOR WOMAN

Are you pregnant? Y N Date of last menstrual period: _____

If x-rays are recommended, your signature is required (below) to verify that you are **not pregnant**.

Signature: _____Date:_____

If **pregnant**, Due Date: _____ Name of OBGYN or Midwife_____

Where will you be birthing your baby? ❑ Hospital ❑ Home ❑ Birthing Center ❑ Other_____

PHYSICAL STRESS: BIRTH AND INFANCY

The birth process can traumatize a baby's spine and cause damage to the spine & nerve system. Please CHECK where and how you were birthed. (If you do not know, please skip to next question)

❑ Home ❑ Natural ❑ Hospital ❑ Caesarian section ❑ Forceps

❑ Breech ❑ Cord around neck ❑ Prolonged labor ❑ Drug induced labor ❑ Suction

PHYSICAL STRESS: CHILDHOOD THROUGH ADULT

The minor & often ignored repetitive physical traumas that we have endured are often too numerous to list.
Please list the major traumas that you remember from your childhood up to the present.
Have you had any accidents due to any of the following? (Check all that apply)

❑ Automobile ❑ Motorcycle ❑ Bicycle ❑ Sports ❑ Playground ❑ Abuse

If yes, state type of injury and date:

_____

Have you ever hurt, broken, fractured, sprained, injured or felt pain in any bones or joints (spine, head, neck, ribs, chest, upper or lower back, pelvis or hips, legs or arms)? ❑ Y ❑ N

If yes, list body parts injured and dates of injuries:

_____

Have you ever been hospitalized or had surgery? ❑ Y ❑ N

If yes, state reason and dates: _____

EMOTIONAL STRESS: CHILDHOOD THROUGH ADULT

It is difficult to separate the emotional stress in our life from the physical response that often occurs. Please indicate if you have ever or are experiencing any of the emotional stresses below:

PREGNANCY HEALTH HISTORY

Childhood Trauma	Y	N	Loss of loved one	Y	N	Abuse	Y	N
Work or School	Y	N	Divorce/separation	Y	N	Financial	Y	N
Lifestyle change	Y	N	Parents' divorce	Y	N	Illness	Y	N

CHEMICAL STRESS: CHILDHOOD THROUGH ADULT

Chemical stress can occur when a substance, that is toxic to the body, is breathed, injected, taken by mouth, or placed on the skin (e.g.: food allergies, drug reactions, exposure to chemicals in the air, etc.) The following will reveal exposures you may have had.

Were you vaccinated? ❑ Y ❑ N If yes, did you have a reaction? ❑ Y ❑ N ❑Unsure

Have you been exposed to any of the following on a regular basis (either in the past or presently)?

❑ Toxic chemicals ❑ Second hand smoke ❑ Drug therapy

❑ Radiation ❑ Chemotherapy ❑ Other

If yes, please list:_____

Do you have allergies or sensitivities to any foods? ❑ Y ❑ N

If yes, please list:_____

Do you presently consume any of the following?

❑ Coffee/caffeine ❑ Alcohol ❑ Tobacco ❑ Over the counter drugs ❑ Prescribed drugs

Please list all medications (prescribed and over the counter):_____

_____

_____

Note: It is imperative that you list all medications as they may have an influence on your care.

QUALITY OF LIFE (presently)

How do you grade your physical health?	❑ Good	❑ Fair	❑ Poor
How do you grade your emotional/mental health?	❑ Good	❑ Fair	❑ Poor
How do you rate your overall "quality of life"?	❑ Good	❑ Fair	❑ Poor

Do you exercise regularly? If yes, how often? _____

Do you take supplements? If yes, please list: _____

Do you follow a special dietary regime? _____

YOUR EXPECTATIONS FROM CHIROPRACTIC CARE

I would like to experience the following benefits from Chiropractic Care: (Check all that apply)

❒ Relief of a symptom or problem

❒ Relief and Prevention of a symptom or problem

❒ Healthier spine and nerve system

❒ Optimal health during pregnancy

❒ OTHER_____

HEALTH HISTORY

FERTILITY HISTORY

Did you have any difficulty in conceiving? _____

How long had you been trying before becoming pregnant? _____

When was your last missed period? _____

Have you ever use any of these fertility methods/drugs? (Please circle all that apply)

IVF:	Y	N	Ovidrel:	Y	N	Other: _____
IUI:	Y	N	Femara:	Y	N	Other: _____
Metformin:	Y	N	Eating:	Y	N	Other: _____

BIRTH HISTORY

Do you have a birth plan? Y N

What birth # is this? _____

Who was your chiropractor for previous births? _____

Any prior miscarriages? Y N

Do you know the sex? Y N Plan to find out? Y N

How long were previous labors? _____

_____

Have you had any ultrasounds? Y N

If yes, please list the medical reason it was done: _____

_____

Who is on your birth team? (Please circle all that apply)

Doula:	Y	N	Husband:	Y	N	Other: _____
Midwife:	Y	N	Kids:	Y	N	Other: _____
OB:	Y	N	None:	Y	N	Other: _____

Where will you be birthing your baby? ❑ Hospital ❑ Home ❑ Birthing Center ❑ Other_____

Name of OBGYN or Midwife_____ Estimated Due Date: _____

INSURANCE INFORMATION:

Subscriber: _____Insurance Co:_____

Subscriber Date of Birth: _____Member ID #:_____

Group #:_____

PLEASE READ AND SIGN

1. I consent to receive communication from Dr. Heather Carmona, D.C. via email, postal mail, text and telephone messaging in connection with my care. ❑ Yes ❑ No If I should withdraw my consent, I will notify the office in writing.

2. I have been informed of the Carmona Chiropractic *"Notice of Privacy Practices for Protected Health Information (HIPAA)"* information.

The information I have provided on this case history form is true and accurate to the best of my knowledge. I give Dr. Heather Carmona, D.C. permission to render care to me today. This initial visit includes a health history consultation, chiropractic exam and evaluation, and any initial care that is determined to be clinically necessary and mutually agreed upon.

Name: (Printed) _____ Date: _____

Signature:_____

Signature of Parent (for minor):_____ Date: _____

Thank you for choosing Dr. Heather Carmona, DC
I look forward to helping you.