



Family First Chiropractic

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Personal and Family Health History

Name _____
 Date _____
 Address _____
 City _____ State _____ Zip _____
 Phone: (H) _____ (W) _____
 E-mail _____
 Date of Birth _____ (Age _____)

Referred By _____
 Social Security # _____
 Occupation _____
 Employer _____
 Marital Status S M D W
 Spouse's Name _____
 Spouse's Occupation _____

Number of Children and Ages

| | | | | |
|------------|-----------|---------|--------|--------------|
| Name _____ | Age _____ | Yes ___ | No ___ | Reason _____ |
| Name _____ | Age _____ | Yes ___ | No ___ | Reason _____ |
| Name _____ | Age _____ | Yes ___ | No ___ | Reason _____ |
| Name _____ | Age _____ | Yes ___ | No ___ | Reason _____ |

Previous Chiropractic Care?

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.

| | <i>Patient</i> | <i>Spouse</i> | <i>Child#1</i> | <i>Child#2</i> | <i>Child #3</i> | <i>Chiropractor's Comments</i> |
|-------------------------------------|----------------|---------------|----------------|----------------|-----------------|------------------------------------|
| Circle all that Apply | | | | | | |
| 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 | _____ |
| Take Drugs? | Y | Y | Y | Y | Y | _____ |
| Fall while learning to walk? | Y | Y | Y | Y | Y | _____ |
| Bullied by your siblings? | Y | Y | Y | Y | Y | _____ |
| Child abuse | Y | Y | Y | Y | Y | _____ |
| Spanking? | Y | Y | Y | Y | Y | _____ |
| Pulled ear/chin | Y | Y | Y | Y | Y | _____ |
| Other | 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? | 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 _____
 Pain or Problem started on _____
 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? _____ Routine? _____ Other? _____
 Is this condition getting progressively worse? _____
 Other Doctors seen for this condition _____
 Any home remedies? _____

Other symptoms:

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Face Flushed | <input type="checkbox"/> Light Bothers Eyes | <input type="checkbox"/> Feet Cold |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Neck Stiff | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Hands Cold |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Pins & Needles in Legs | <input type="checkbox"/> Ears Ring | <input type="checkbox"/> Stomach Upset |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Pins & Needles in Arms | <input type="checkbox"/> Fever | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Numbness in Fingers | <input type="checkbox"/> Fainting | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Numbness in Toes | <input type="checkbox"/> Cold Sweats | <input type="checkbox"/> Buzzing in Ear |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Loss of Smell | |
| <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Loss of Taste | |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Depression | <input type="checkbox"/> Diarrhea | |

Have you been under drug and medical care? _____
 What medications are you taking? _____
 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 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Mother's Side | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Upon the completion of your first visit, you will receive a Chiropractic Report to discuss the different types of Active Life Plans that are available to you. Chiropractic Active Life Plans are designed to help get you feeling better quickly and to help you and your family be as healthy as possible. Please review the explanations of the Chiropractic Active Life Plans prior to your Chiropractic Report appointment so you can choose the level of participation that supports you in reaching all of your health goals.

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

Please check all that apply

- | | |
|---|---|
| <input type="checkbox"/> Feel better quickly | <input type="checkbox"/> Have a healthier body by keeping my nerve system healthy |
| <input type="checkbox"/> Have a healthier spine | <input type="checkbox"/> Live a healthier lifestyle |

Signature

Date