Easton Health Solutions Chiropractic Center

285 Washington Street, Suite 4, North Easton, MA 02356
Phone (508) 230-2323 www.ehschiro.com

Please fill out this form as completely and accurately as possible.

Today's Date _____ Patient File # _____

PERSONAL DATA

Name_____ Age _____ Date of Birth _____
Parents' names (if you are under 18) _____
Home Address_____ City _____ State_____ Zip _____
Home Phone (_____) _____ Business Phone (_____) _____
Cell Phone (_____) _____ E-Mail Address_____
Occupation_____ Employer _____
Marital Status ❑ S ❑ M ❑ D ❑ W Spouse/Partner's Name:_____
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 Easton Health Solutions Chiropractic Center can address for you?

_____

Are these concerns affecting your quality of life? (Please circle only those applicable to you)

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	Other Y N

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?

_____

How was your experience?_____

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 why: _____

FOR WOMEN ONLY

Are you pregnant? ❑Y ❑N Possible/Unknown
If pregnant due date?_____ Name of OBGYN or Midwife:_____
If x-rays are recommended, your signature is required to indicate that you are **not pregnant**.
Signature:_____ Date:_____

HEALTH, WELLNESS AND CHIROPRACTIC CARE

The primary system in the body, which coordinates health, is the CENTRAL NERVE SYSTEM. The vertebrae, the bones of the spinal column, surround and protect the delicate NERVE SYSTEM. Chiropractors are specialists trained in "early detection" of injury to the SPINE AND NERVE SYSTEM.

The information below will help us to see the types of PHYSICAL, EMOTIONAL and CHEMICAL stressors you have been subjected to and ***how they may relate to your present spinal, nerve and health status.***

CURRENT PHYSICAL STRESS

Please describe your usual work position and how long you maintain it during the day. For example, do you work at a computer, talk on the phone or stand at a machine for most of the day?

_____

Does your job require regular airline travel and hotel stays? ❑Y ❑N If yes, how often? _____
How long is your daily commute? _____ How many hours do you typically work in a week? _____
How many hours per week do you watch T.V.? ____ Are you sitting or lying on a couch? _____
Please describe your exercise/sports program including type and frequency:

_____

_____

How many hours of sleep do you typically get each night? _____ Do you sleep well? ❑Y ❑N
Do you ever sleep on your stomach? ❑Y ❑N How old is your mattress? _____
Do you wear orthotics (foot supports) or a heel life? ❑Y ❑N If yes, for how many years? _____
Do you use a cervical pillow? ❑Y ❑N

PAST PHYSICAL TRAUMAS

Were you born at home or in a hospital? Medication used? ❑Y ❑N C-section? ❑Y ❑N Forceps/vaccum ? ❑Y ❑N
Did you have any **significant childhood injuries**? (fractures, stitches, falls, sports-related, etc.) Please list dates, injury and treatment: _____

_____

Have you had any **significant adult injuries**? Please list dates, injury and treatment:

_____

_____

Have you had any **automobile accidents or work-related injuries**?
Date:_____ driver/front passenger/rear passenger Seatbelt? Y N Airbag discharged? Y N
Injuries: _____ Care received: _____
Date:_____ driver/front passenger/rear passenger Seatbelt? Y N Airbag discharged? Y N
Injuries: _____ Care received: _____

COVID 19

Within the last 14 days have you experienced any of the the following symptoms:

Fever	❑Y ❑N	Shortness of breath	❑Y ❑N
Cough	❑Y ❑N	Muscle aches	❑Y ❑N
Fatigue	❑Y ❑N	Intestinal issues	❑Y ❑N

Signature:_____ Date:_____

CHEMICAL STRESS

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.
Have you been **exposed to** any of the following on a regular basis, past or present?
❑ Toxic chemicals ❑Radiation ❑Second hand smoke ❑Chemotherapy ❑Drug therapy ❑Other
If yes, please explain:_____
Do you have any **food allergies**? ❑Y ❑N **If yes, please list:** _____
_____
How many **fast food meals** do you eat per week? _____
How many **alcoholic beverages** do you drink per week? _____
Do you smoke **tobacco products**? ❑Y ❑N If yes, how many packets per day? _____
How many glasses of **water** do you drink per day? _____
How many **caffeinated beverages** (coffee, tea, soda) do you drink per day? _____
Are you currently on **prescription** or **over-the counter medication?** ❑Y ❑N Please list, indicating dose & frequency_____
_____
Please list any **nutritional supplements** you are taking: _____
_____
How do you rate your **physical health**? ❑Excellent ❑Good ❑Fair ❑Poor

QUALITY OF LIFE

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

EXPECTATIONS

I would like to have 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 on all levels
What are your top three health goals?
1. _____
2. _____
3. _____

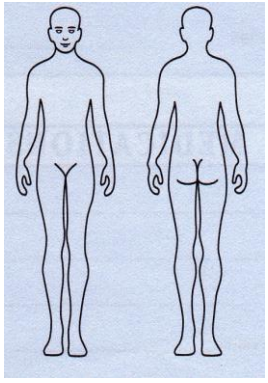
CHIROPRACTIC CLINICAL OBJECTIVE

Physical, emotional and chemical STRESSES, common to our contemporary lifestyles, can result in misalignment of the spinal column causing damage to the nerve system. The result is a condition called Vertebral Subluxation. The Chiropractic exam/evaluation is specifically designed to detect Vertebral Subluxations in all phases of their progression.

Many common symptoms and conditions are caused by the interference and stress on the nerve system. Please place a (X) on conditions that you are currently suffering from and a (O) on any conditions you have had in the past.

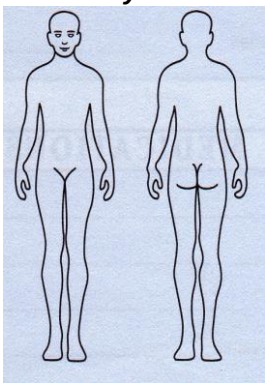
__Arthritis	__Headache	__Asthma
__Back Curvature	__Migraine Headache	__Chest Pain
__Mental / Emotional Disorders	__Neck Pain R/L	__Difficult Breathing
__Diabetes	__Shoulder Pain R/L	__Heart Problems
__Swollen or Painful Joints	__Numbness or Tingling	__Heart Attack
__Convulsions / Epilepsy	in arms, or hands R/L	__Stroke
__Skin Problems	__Carpal Tunnel Syndrome R/L	__Bruit
__Bruise Easily	__Dizziness	__High / Low Blood Pressure
__Cancer	__Ringing in Ears	__Varicose Veins
__Allergies	__Hearing Loss	__Liver Trouble
__Frequent Colds	__Loss of Balance	__Gall Bladder Trouble
__Upper Back Pain / Stiffness	__Digestive Problems	__Mid Back Pain / Stiffness
__Excessive Gas	__Depression	__Pain with cough, or strain
__Constipation / Diarrhea	__Attention Disorder	__Hip Pain
__Prostate Problems	__Anxiety Disorder	__Low Back Pain / Stiffness
__Impotence	__Eating Disorder	__Sciatica
__Kidney Problems	__Trouble Concentrating	__Numbness or Tingling in
__Frequent Urination	__Loss of feeling in legs or feet (right or left)	
__Menstrual Problems / PMS	__Ear Infection	__Muscle Tightness
__Menopausal problems	__Learning Disability	__Trouble sleeping

Primary Health Concern:_____



○ Please indicate the location of your pain or discomfort on the diagram
○When did this problem start? _____
○Have you ever had this problem before? □No □Yes If yes, when_____
○Please indicate quality of the pain:
□ Dull □ Burning □ Numb □ Stabbing □ Tingling □ Cramping
○Does this pain radiate or travel? □No □Yes If yes, please indicate on diagram
○Please indicate the severity of the pain on a scale from 1-10 (1 minor pain 10 major pain) 1-----2-----3-----4-----5-----6-----7-----8-----9-----10
○What makes this pain or condition better? _____Worse?_____
○What have you done to treat this problem? _____
_____
_____

Secondary Health Concern:_____



○ Please indicate the location of your pain or discomfort on the diagram
○When did this problem start? _____
○Have you ever had this problem before? □No □Yes If yes, when_____
○Please indicate quality of the pain:
□ Dull □ Burning □ Numb □ Stabbing □ Tingling □ Cramping
○Does this pain radiate or travel? □No □Yes If yes, please indicate on diagram
○Please indicate the severity of the pain on a scale from 1-10 (1 minor pain 10 major pain) 1-----2-----3-----4-----5-----6-----7-----8-----9-----10
○What makes this pain or condition better? _____Worse?_____
○What have you done to treat this problem? _____
_____
_____

I hereby certify that the information provided is true and accurate.

Patient Signature: _____ _____ Date: _____