Welcome to North Boulder Chiropractic
David Boynton DC

Today's Date ____/____/____

GENERAL INFORMATION

Full Name ______________________________________ Age ___ DOB ____/____/____

Home Phone (____) ___________ Cellular Phone (____) __________Fax (___) _______

E-mail Address ____________________________ Social Security # _________________

Home Address __________________________ City ____________ State ___ Zip ______

Marital Status S M D W Name of Spouse ____________________________________

Names and Ages of Children ____

____

Have Your Children Received Previous Chiropractic Care? Y N __________________

Parents Name (if you are under 18 years of age) __________________________________

Occupation _________________________ Employer ______________________________

Business Address ______________________ City _____________ State ___ Zip ______

Business Phone (____) __________________ May we contact you at work? Y N

Emergency Contact ____________________ Phone Number (____) _____________

Whom may we thank for referring you to North Boulder Chiropractic?

____

REASON FOR SEEKING CHIROPRACTIC CARE

What concerns do you feel we can address for you?
____

____

____

Is the above concern affecting any of the activities below? (Please circle)

Work: Yes No Recreation/Play: Yes No Sleep: Yes No

Social life: Yes No Walking: Yes No Sitting: Yes No

Exercise: Yes No Eating: Yes No Other: _________________________

OTHER DATA

Have you ever received Chiropractic care? Yes No With whom? ___________________

Date of last visit: ____/____/____ Reason for ending care? ________________________

Name of current medical doctor: ______________________Phone # (___)___________

Date of last medical consultation and result: ____/____/____-_______________________

Do you consult him/her regularly? Yes No If so, why? ___________________________

For women: Are you pregnant? Yes No Date of last menstrual period: ____/____/____

HEALTH, WELLNESS AND CHIROPRACTIC CARE

Throughout life, stresses and traumatic events can damage the spine and nerve system. These stresses may be PHYSICAL, CHEMICAL and/or EMOTIONAL in nature. Understanding the PHSYICAL, CHEMICAL, and/or EMOTIONAL stresses that have acted upon your spine and nerve system assists us in serving you. We thank you in advance for answering the following questions as accurately and completely as possible.

HISTORY OF PHYSICAL STRESS (Birth to Present)

Research indicates that the birth process can cause trauma to a baby's spine and nerve system. Please indicate to the best of your recollection how you were birthed:

Was your birth: (Circle all that apply)

Drug induced   C section   Breech   Natural   Forceps   Hospital

Vacuum extraction   Prolonged   Umbilical cord around neck   Home Birth

General Physical Trauma:

Most traumas occur in the early years (between birth and the early twenty's). It is during those years that your spine and nerve system is growing and most vulnerable. The information below will help us to consider the types of stresses that you have been subjected to.

Have you had any accidents related to the following: (Circle all that apply and give dates.)

Automobile   Motorcycle   Bicycle   Sports   Other: ________________________

If yes, please explain: ____

____

Have you ever injured your nerve system or spine? (Head, neck, back, pelvis, hips): Y N

If yes, please explain: ____

____

Have you broken any bones or sprained any part of your body? Yes   No

If yes, please explain: ____

____

Have you ever had surgery or have you been hospitalized? Yes   No

If yes, please explain: ____

HISTORY OF CHEMICAL STRESSES

Chemical stresses occur during life due to any substance that is breathed, injected, taken orally, or placed on the skin that is toxic to the body. The following will give us insight into any exposures you may have had.

(Please circle those that apply)

Have you been vaccinated? Yes No

Do you currently or have ever taken?

Prescriptions drugs Over the counter drugs Recreational drugs

Have you been exposed to or currently exposed to?

Chemicals Fumes Dust Smoke

Do you consume? Alcohol Coffee/caffeine Tobacco

HISTORY OF EMOTIONAL STRESSES

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

(Please circle those that apply)

Childhood trauma	Yes No	Loss of loved one	Yes No	Illness	Yes No
Relationships	Yes No	Family	Yes No	Work or School	Yes No
Divorce/Separation	Yes No	Financial	Yes No	Abuse	Yes No
Lifestyle change	Yes No	Parental Divorce	Yes No	Other	Yes No

QUALITY OF LIFE

(Please circle those that apply)

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

PLEASE CHECK THE CHOICE THAT MOST CLEARLY DESCRIBES YOUR CURRENT GOALS FOR HEALTH AND WELLBEING:

Please CHECK ALL that apply:

_ I am only concerned with my immediate problem.

_ I am only concerned with my immediate problem and preventing its return.

_ I want to achieve optimum function, health and well-being on every level that is available to me!

In addition to the main reason for your visit today, what additional health objectives do you have for your future?

____

____

Have you ever been to another doctor who put you on a Health Development Program? If so, how long were you able to stay on the program, and what were your results?

____

____

Are you as healthy (or healthier) today as you were 5 years ago? ( )YES ( ) NO
If yes, what strategies have you used? ____

____

Will you be as healthy (or healthier) as you are today, 5 years from now?
( )YES ( )NO ( )Don’t Know

If yes, what strategies will you implement to get there? ___________________________
____

If no, what strategies could you implement to get there? __________________________
____

I hereby certify that the statements and answers given on this form are accurate to the best of my recollection and knowledge. I agree to allow this office to perform an assessment on me in order to make as complete an evaluation as possible.

Signed _____________________________ Date ____/____/____