Christopher Bosco, DC Chiropractor

Health History Form **Please Print**

Name ____Date_________________________

Home Phone (   ) ____________ Work Phone (   ) ______________ Cell Phone (   ) ____________________

Address: ____Email_______________________________

City ____ State ___________ Zip ____________________

Would you like our Health Newsletter emailed to you? Please circle. Yes No

Sex: ______ Age: _____ Date of Birth: ___________ Height: _______ Weight: ________Desired Weight:_______

Who referred you to our practice? Please Circle: Self / Health professional / Family / Friend / Other: _________

Please list your health goals/expectations: ____

____

Name of Primary Care Physician Phone # Date of last visit/purpose
____________________________ (   ) _____________ ____

____

Name of Dentist Phone # Date of last visit/purpose
____________________________ (   ) _____________ ____

____

# of Cavities, Root Canals & Crowns: ____

Name of Chiropractor Phone # Date of last visit/purpose
_____________________________(   )______________ ____

____

*Do you have a Pacemaker or other electronic implanted device? Yes No What kind? ________________

In case of an emergency whom should we contact: Name_______________________ Phone________________

Please circle: are you: Right Handed Left Handed

1. Ethnicity: Please Circle: Caucasian / African-American / Asian / Hispanic / American Indian / Other: ____________

2. Marital Status: Please Circle: Currently: Single / Married / Divorced / Separated / Widowed
   If married, how long? __________________ If divorced, how long? ________________

   Females: Are you pregnant? Please circle. Yes No If Yes, how far along? _______________________________

3. Children: Girl(s): _______Ages________; Boy(s): _______Ages________ (Please indicate vaginal birth or C-section)

4. What are your one or two primary reasons to BioBalance/Reduce Stress? _________________________________

____

5. When did you last feel well (absent of all symptoms)? ____

   1st Major Diagnosis: _________________________________Date first occurred/diagnosed: __________________

   Related symptoms: ____Frequency:_______________

   What makes condition improve? ______________________________ Makes worse: _________________________

   Do you think this will resolve itself? Please circle. Yes No

   2nd Major Diagnoses: _________________________________Date first occurred/diagnosed: __________________

   Related symptoms: ____Frequency:_______________

   What makes condition improve? ______________________________ Makes worse: _________________________

   Do you think this will resolve itself? Please circle. Yes No

   3rd Major Diagnosis: __________________________________Date first occurred/diagnosed: __________________

   Related symptoms: ____Frequency:_____________

   What makes condition improve? ______________________________ Makes worse: _______________________

   Do you think this will resolve itself? Please circle. Yes No

6. Pervious Treatment: Use back of sheet if necessary.

Name of practitioner	Phone number	Diagnosis/Treatment/outcome
____________________________	(_____) _____________	____
____________________________	(_____) _____________	____
____________________________	(_____) _____________	____

7. Significant birth events: Please Circle. Premature? Yes No. If Yes, how many days premature? _______________

   Other: ____

8. Childhood illnesses. Please Circle: Colic, Earaches/Infections, Mumps, Measles, Chickenpox, Other ______________
____

9. Please circle any surgeries (continue on back if necessary). If any problems, please explain.
Tonsils / Adenoids / Appendix / Gallbladder / Wisdom Teeth / Other ____________________________________

____

10. List all injuries/Dates (continue on back if necessary): ____

11. Have you ever been diagnosed with any of the following: Please Circle. Heart disease / Kidney disorders / Stroke / Seizures / Thyroid issues / Arthritis / High BP / Glaucoma / Diabetes / Obesity / High cholesterol / Ulcers / Periodontal disease / Oral gum / Bone problem / Cancer / Whiplash / Liver disease / Cataracts / Depression / Manic-depressive disorder. **Other Diagnoses?** (Please list):____

____

12. Do you suffer from headaches? Yes No. If Yes, how often per month? _________ Type of pain:________________

13. Family history. Please circle and note if on Mother's or Father's side or Both. Acne / Anaphylactic Reactions / Asthma / Alcoholism / Cancer / Diabetes / Depression / Eczema / Epilepsy / Early dementia / Herpes / Hepatitis / Heart disease / High BP / Hysterectomy / Intestinal Disorders / Kidney Disorders / Manic-depressive disorder / Neurological Disorders / Obesity / Stroke / Schizophrenia / Seizure Disorders / Thyroid issues. Other ____________

____

14. Sleep (Please circle): Trouble falling asleep? Yes No Trouble staying asleep? Yes No Hours per night: ______

Time you go to bed and wake up: _________________ Do you wake up at night: Yes No Why?___________

Trouble falling back to sleep after waking up? Yes No Why? ____

15. List all medications, prescription and over-the-counter, you are now or have been taking.

	Medication	Physician	Dosage /How Long/Condition used for
1.			
2.			
3.			
4.			
5.			

16. List all supplements/alternative remedies (vitamins, minerals, herbs, etc.) you are now taking.

	Supplement	Size (mg, mcg, etc.)	Daily Dose
1.			
2.			
3.			
4.			
5.			

17. What is your most important health goal? ____

18. On a scale from 1 to 10 (low to high) assign a number to the amount of stress you experience in your daily life._____

19. List traumatic or shocking events throughout your lifetime and approximate dates: ____________________________

____

____

20. Do you eat healthy (Organic/grass fed)? Yes No How often? Every meal or please describe your daily/weekly eating habits: ____

____

21. Do you drink/eat and how much (please circle): regular or diet soda / anything low or no fat / anything pasteurized

22. Do you have any cravings? Yes No

23. What type of work do you do? ____

24. Rate your overall energy level. Please circle: Low / Med / High / Very High

25. Is there any time during the day that your energy level is low? Please circle. Yes No If yes, when or what time, ie; after eating? ____

26. Rate what you think your General Health is. Please circle: Very Poor / Poor / Good / Great / Excellent
Why? ____

27. Do you exercise: Please circle. 1-3x/ week 3-5x/ week 5-7x/ week Is it: Cardio / Weights / CrossFit/HIIT

28. Rate your interest in Overall Wellness. Please circle one. Low / Med / High / Very High

29. How motivated are you to make the necessary changes to increase your Overall Wellness? Please circle.

Low / Med / High / Very High

30. What do you have the most trouble changing in your health habits? ______________________________________

____

31. **Sensitivities:** List all known. Foods, Grasses, Trees Etc. (including medications) **or** No known sensitivities.

____

32. Serious allergic reaction? Please circle. No Yes. explain____

____ ______________

Patient Signature **Date**

____ ______________

Parent/Legal Guardian Signature (If under 18 years old) **Date**