

**GEORGE'S CHIROPRACTIC  
HEALTH CENTER**

1676 Manheim Pike Phone 717 569 5731  
Lancaster, PA 17601 Fax 717 569 4195  
[www.georgeschiropractic.com](http://www.georgeschiropractic.com)  
[www.georgeschiropractic.wordpress.com](http://www.georgeschiropractic.wordpress.com)  
gchc2@verizon.net

---

*Personal & Family Health History*

Date \_\_\_\_\_

Account # \_\_\_\_\_

How did you hear About Us?  Location  Phone Book  Screening  Advertisement  
 Lecture  Referred by \_\_\_\_\_

\*\*\*\*\*

Child  Teenager  College Student  Adult (18+)  Medicare

Name \_\_\_\_\_ M. I. \_\_\_\_\_ Last Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_

SS# \_\_\_\_\_ E-Mail \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex  M  F Marital Status  S  M  Partner

Occupation: \_\_\_\_\_ Employer \_\_\_\_\_

Spouse/Partner's Name \_\_\_\_\_ Occupation \_\_\_\_\_

Name of Children & Ages

1 <sup>st</sup> _____	Age _____	4 <sup>th</sup> _____	Age _____	7 <sup>th</sup> _____	Age _____
2 <sup>nd</sup> _____	Age _____	5 <sup>th</sup> _____	Age _____	8 <sup>th</sup> _____	Age _____
3 <sup>rd</sup> _____	Age _____	6 <sup>th</sup> _____	Age _____	9 <sup>th</sup> _____	Age _____

Have YOU ever been to a Chiropractor before?  Y  No Results \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Financial Responsibility  Personal  Parent  Auto  Worker's Compensation

***Growth & Development***

- Head Injuries     Spine Injuries                     Child Abuse    Physical    Sexual    Verbal
- Fallen Down the Stairs    Ride Bumping Cars    Ever Unconscious    Any Broken Bones

***Current Health Habits***

- Smoke       Poor Diet                     Use Recreational Drugs                     Use Artificial Sweeteners
- Drink Alcohol                     Take Yearly Flu Shots                     No Exercise Program
- Have Family Stress                     Have Mental Stress                     Have Occupational \Stress
- Not Getting Enough Rest                     Not Drinking 6-8 Glasses of Water/Day

***Reason for today's visit*** \_\_\_\_\_

How long have you had this **Symptom**?       Days     Weeks     Months     Years

What Activities **Aggravate your Condition**?    Standing    Walking    Sitting    Bending

Twisting    Other \_\_\_\_\_

Condition **Interfering with:**   **Work**    Y    N    **Sleep**    Y    N    **Daily Routine**    Y    N  
**Progressively Getting Worse**    Y    N    Same

**Other Doctors Seen** for this Problem     Y     N    Who \_\_\_\_\_

---

**Falls, Accidents that You Remember?** \_\_\_\_\_

What Sports were you involved with in the Past? \_\_\_\_\_

Explain **Car/Motorcycle/Buggy Accidents** even if they were minor? **Write Year of accident**

\_\_\_\_\_  Rear end    \_\_\_\_\_  Broadside    \_\_\_\_\_  Head on    \_\_\_\_\_  Thrown out    \_\_\_\_\_  Rolled

---

---

---

---

***Check Other Symptoms in the last 6 months or since accident.***

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> Acid reflux    | <input type="checkbox"/> Diarrhea        | <input type="checkbox"/> High/low blood pressure | <input type="checkbox"/> Neck stiff                  |
| <input type="checkbox"/> Allergies      | <input type="checkbox"/> Dizziness       | <input type="checkbox"/> Irritability            | <input type="checkbox"/> Numbness in toes/fingers    |
| <input type="checkbox"/> Balance        | <input type="checkbox"/> Ears ring R L   | <input type="checkbox"/> Knee pain R L           | <input type="checkbox"/> Panic attacks               |
| <input type="checkbox"/> Bowel problems | <input type="checkbox"/> Fainting        | <input type="checkbox"/> Light bothers eyes      | <input type="checkbox"/> Pins & needles in arms/legs |
| <input type="checkbox"/> Carpal tunnel  | <input type="checkbox"/> Fatigue         | <input type="checkbox"/> Loss of memory          | <input type="checkbox"/> Shortness of breath         |
| <input type="checkbox"/> Chest pains    | <input type="checkbox"/> Feet /hand pain | <input type="checkbox"/> Low Back pain           | <input type="checkbox"/> Sinus                       |
| <input type="checkbox"/> Cold sweats    | <input type="checkbox"/> Fevers          | <input type="checkbox"/> Menstrual cramp         | <input type="checkbox"/> Sleeping problems           |
| <input type="checkbox"/> Constipation   | <input type="checkbox"/> Gas             | <input type="checkbox"/> Mood swings             | <input type="checkbox"/> Stomach upset               |
| <input type="checkbox"/> Depression     | <input type="checkbox"/> Headaches       | <input type="checkbox"/> Neck pain               | <input type="checkbox"/> Tightness between shoulders |
- Other Symptoms? \_\_\_\_\_
- 

Explain any Surgeries with Year? \_\_\_\_\_

---

Taking Medications for What Symptoms? \_\_\_\_\_

---

**If you could get rid of one symptom today, maybe the symptom that brought you into our office or another symptom; to eliminate that symptom out of your life forever, the one symptom that AFFECTS your lifestyle the most, WHAT WOULD IT BE?** \_\_\_\_\_

How long have you had this symptom? Days    Weeks    Months    Years

**When that symptom is at its absolute worst, how does it make you feel?**

---

---

**If you could get rid of this symptom, what would your commitment be from 1 through 10, 10 being the highest commitment, 1 being the lowest commitment? Circle 1 2 3 4 5 6 7 8 9 10 \_\_\_\_\_**

**As a result of my chiropractic care, I would like to achieve: (Please check all that apply)**

- Symptom Relief    More Energy    Become More Active    Healthier Spine
- Healthier Body    Healthier Lifestyle    Better Quality of Life

***What type of care do you want?***

**Relief Care** is necessary to reduce or eliminate your symptoms or pain, but not the cause of it. It is the same as drying a floor that was getting wet from a leak, but not fixing the leak. This care is not recommended because the health problem is never handled, progressively gets worse over time. **(Medical Model)**

**Corrective Care** to correct or stabilize the health problem by addressing the cause of why your body may not be healing, adapting or repairing, which is controlled by your nerve system. Corrective care varies in length of time, but is more lasting and improves the overall health of a person. Corrective and stabilization care goals are to enhance your Quality of Life. This care is recommended by George's Chiropractic Health Center. **(Quality of Life Model)**

**Not sure** \_\_\_\_\_ Date \_\_\_\_\_  
Practice Member's Signature or Guardian

---

***Do Not Write Below This Line***

---

***Do Not Write Below This Line***

Pregnant  Y  N   Spinal X-rays  Y  N    Computer Evaluation    Did Not Continue

---

Comments \_\_\_\_\_

---

---

---

---

---

---

---