Thank you for choosing Naas Chiropractic Clinic!

These questions are meant to help you think about injuries or traumas that occurred before you became an adult or began to take an active role in your health care. There are Yes and No checkboxes to the left of the question, and a space to leave comments to the right. If you do not know the answer to a question, you may leave it blank.

Patient Name: _____ **Date:** _____

Yes	No		Comments
		1. Your Birth Process	
☐	☐	Was the delivery long or difficult?	_____
☐	☐	Forceps/Vacuum Extraction?	_____
☐	☐	Caesarean?	_____
☐	☐	Breach/Cephalic?	_____
☐	☐	Mother given drugs during delivery?	_____
☐	☐	Was labor induced?	_____
		2. Growth & Development	
☐	☐	Were you breast fed?	_____
☐	☐	Childhood Sicknesses?	_____
☐	☐	Accidents?	_____
☐	☐	Surgery?	_____
☐	☐	Drugs?	_____
☐	☐	Were you picked on by siblings?	_____
☐	☐	Child Abuse (Spanking, Pulled Ear, Other)	_____
☐	☐	Chair pulled out when sat down?	_____
☐	☐	Did you fall down the stairs?	_____
☐	☐	Were you yanked by your arm?	_____
☐	☐	Did you have other traumas? What / When?	_____
		3. Current	
☐	☐	Diet (Do you consistently eat healthy foods?)	_____
☐	☐	Have you been in any accidents?	_____
☐	☐	Teeth Problems?	_____
☐	☐	Eye Problems?	_____
☐	☐	Hearing Problems?	_____
☐	☐	Sleeping habits (nightmares, quality, hrs/night?)	_____
☐	☐	Did/do you have occupational stress?	_____
☐	☐	Physical Stress?	_____
☐	☐	Mental Stress?	_____
☐	☐	Hobbies/Sports Injuries?	_____
☐	☐	Sleeping posture: ☐Side ☐Stomach ☐Back	_____

Symptoms & Ill Health

These questions are about what is currently going on with your health, including what has brought to seek chiropractic care.

Present Complaint (Be Brief): _____
Pain or Problem Started On: _____
Pains are: ☐Sharp ☐Dull ☐Constant ☐Intermittent
What activities aggravate your condition/pain? _____
What activities lessen your condition/pain? _____
Is the condition worse during certain times of the day? _____
Is this condition interfering with work? Yes No
Sleep? ____ Yes ____No **Routine?** ____Yes ____No **Other?** _____
Is this condition getting progressively worse? _____
Other doctors seen for this condition: _____
Any home remedies? _____
Other Symptoms:

☐ Headaches	☐ Neck Pain	☐ Sleeping Problems	☐ Back Pain	☐ Nervousness
☐ Tension	☐ Irritability	☐ Chest Pains	☐ Dizziness	☐ Face Flushed
☐ Neck Stiff	☐ Fatigue	☐ Depression	☐ Light Sensitivity	☐ Buzzing In Ears
☐ Loss of Memory	☐ Numbness in Toes		☐ Numbness in Fingers	
☐ Ears Ring	☐ Fever	☐ Fainting	☐ Loss of Smell	☐ Loss of Balance
☐ Loss of Taste	☐ Cold Sweats	☐ Constipation	☐ Pins & Needles in Arms	
☐ Diarrhea	☐ Feet Cold	☐ Stomach Upset	☐ Hands Cold	☐ Pins & Needles in Legs

Have you been under drug and medical care? _____
Is there a family history of:

Maternal Grandmother
☐ Heart Disease ☐ Arthritis ☐ Cancer ☐ Diabetes ☐ Other: _____

Maternal Grandfather
☐ Heart Disease ☐ Arthritis ☐ Cancer ☐ Diabetes ☐ Other: _____

Mother:
☐ Heart Disease ☐ Arthritis ☐ Cancer ☐ Diabetes ☐ Other: _____

Paternal Grandmother:
☐ Heart Disease ☐ Arthritis ☐ Cancer ☐ Diabetes ☐ Other: _____

Paternal Grandfather:
☐ Heart Disease ☐ Arthritis ☐ Cancer ☐ Diabetes ☐ Other: _____

Father:
☐ Heart Disease ☐ Arthritis ☐ Cancer ☐ Diabetes ☐ Other: _____