

**Marshfield Chiropractic**  
**20 Congress Street, Suite 1**  
**Marshfield, MA 02050**

Please print clearly and fill in completely

Print name \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Who may we thank for referring you to our office? \_\_\_\_\_

*Please check*  Right handed?  Left handed?  Married?  Single?  Divorced?  Widowed?

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**Health History:**

Reason for seeking chiropractic care: \_\_\_\_\_

Describe any other health problems, including how long you've had them: \_\_\_\_\_

Name, phone, and address of PCP: \_\_\_\_\_

List any current medications: \_\_\_\_\_

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**Family History:**

At our office we are not only interested in your health and well-being, but also the health and well-being of your family and loved ones. Please feel free to mention below any health concerns you may have about your:

Spouse \_\_\_\_\_

Children \_\_\_\_\_

Parents \_\_\_\_\_

Siblings \_\_\_\_\_

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**Chiropractic History:**

Have you ever been to a Chiropractor before? Yes? No? If yes, Doctor's name \_\_\_\_\_

Date of last chiropractic visit \_\_\_\_\_ Reason for care \_\_\_\_\_

Date of last chiropractic x-rays \_\_\_\_\_ How long were you under care? \_\_\_\_\_

Are other family members under chiropractic care? Yes? No? Who? \_\_\_\_\_

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**Current Complaint:**

I would describe the pain as: sharp? dull? comes and goes? travels? constant?

Since the problem started, it is: about the same? getting better? getting worse?

What makes it worse? \_\_\_\_\_

It interferes with: work? sleep? walking? sitting? hobbies? leisure?

**Please Fill in Below**

If you have had the following, or if you suffer  
From the following, *please check v*

Condition, Symptom or Problem	Constantly or Frequently	Sometimes or Occasionally
Headache	?	?
Migraines	?	?
Neck Pain	?	?
Shoulder Pain	?	?
Arm/Hand Pain	?	?
Mid Back Pain	?	?
Low Back Pain	?	?
Hip Pain	?	?
Leg/Foot Pain	?	?
Disc Problems	?	?
Arthritis	?	?
Other Joint Pain	?	?
Numbness/Tingling	?	?
Joint Swelling	?	?
Dizziness	?	?
Heart Burn/Ulcers	?	?
Weakness	?	?
Fatigue	?	?
Nervousness	?	?
Insomnia	?	?
Anxiety	?	?
Depression	?	?
Heart Problems	?	?
Frequent Colds	?	?
Ringing In Ears	?	?
Hearing Loss	?	?
Cough	?	?
Chest Pains	?	?
Female Problems	?	?
Allergies	?	?
Asthma	?	?
Cancer	?	?
Osteoporosis	?	?
Diabetes	?	?
Hypoglycemia	?	?
Constipation	?	?
Diarrhea	?	?
Skin Conditions	?	?
Stroke	?	?
Urinary Problems	?	?

Below, please fill in any other Health  
information you feel we might need  
For your care.

**Childhood History**

Research is showing that many of the health challenges that occur later in life have their origins during the developmental years, some starting at birth. Please answer these questions to the best of your ability.

Did you have any childhood illnesses?	Yes ?	No ?
Did you have any serious falls as a child?	Yes ?	No ?
Did you play any sports?	Yes ?	No ?
Did you have any surgery?	Yes ?	No ?
Any major falls? (i.e. tree, seesaw, crib, etc.)	Yes ?	No ?
Any car accidents?	Yes ?	No ?
Prolonged use of medicines? (i.e. antibiotics, inhalers, etc.)	Yes ?	No ?
Were you vaccinated?	Yes ?	No ?

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**Adult History (age 18 to present)**

Do / did you smoke?	Yes ?	No ?
Do/ did you drink alcohol?	Yes ?	No ?
Do / did you play adult sports?	Yes ?	No ?
On a scale of 1=none to 10=severs, rate your stress at home _____ at work _____		
On a scale of Poor, Good, Excellent; describe your:		
Diet _____ Exercise _____ Sleep _____ General Health _____		
Have you ever:		
Bought bottled water?	Yes ?	No ?
Belonged to a health club?	Yes ?	No ?
Consumed vitamins or supplements?	Yes ?	No ?

**Wellness Commitment**

At Marshfield Chiropractic we are dedicated toward achieving the goal of total lasting health for our members. To better help you achieve this we need to understand your commitment toward being healthy. We do not ask for a financial commitment, but we do ask for your cooperative commitment. Based on a scale of 10% to 100%, please circle your personal level of commitment toward obtaining and maintaining health and wellness.

10% \_\_\_ 20% \_\_\_ 30% \_\_\_ 40% \_\_\_ 50% \_\_\_ 60% \_\_\_ 70% \_\_\_ 80% \_\_\_ 90% \_\_\_ 100% \_\_\_

*The statements made on this form are accurate and to the best of my recollection and I agree to allow this office to examine me for further evaluation:*

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Signature

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Date