

Marshfield Chiropractic
1020 Plain Street, Suite 140
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 circle - Right handed Left handed Married Single Divorced Widowed

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: _____

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 _____

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? _____

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* ✓

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

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:
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:

Signature

Date