



EHRESMAN
FAMILY
CHIROPRACTIC

Carl E. Ehresman II, D.C.

Full Name _____ Date ____/____/____

GENERAL INFORMATION

Age _____ Date of Birth ____/____/____ Social Security # _____ - _____ - _____ Email address _____

Home Phone (____) _____ Cell Phone (____) _____ Fax (____) _____

Mailing Address _____ City _____ State ____ Zip _____

Marital Status S M D W Name of Spouse _____

Names and Ages of Children _____

Have your children received previous chiropractic care? Yes No

Name of Parent (if you are under 18 years of age) _____

Your Occupation _____ Employer _____

Business Address _____ City _____ State ____ Zip _____

Business Phone (____) _____ May we contact you at work? Yes No

Emergency Contact Name _____ Phone Number (____) _____

Whom may we thank for referring you to Ehresman Family Chiropractic? _____

Would you like to receive Dr. Ehresman's monthly email newsletter? Yes No

REASON FOR SEEKING CHIROPRACTIC CARE

What concerns do you feel Ehresman Family Chiropractic can address for you? _____

Is the above concern affecting any of the activities below? (check all that apply)

- Work Recreation/Play Sleep Social life Walking
- Sitting Exercise: Eating Other _____

OTHER INFORMATION

Have you ever received Chiropractic care? Yes No With whom? _____

Date of last visit: ____/____/____ Reason for ending care? _____

Name of current medical doctor: _____ Phone (____) _____

Date of last medical consultation: ____/____/____ Result: _____

Do you consult him/her regularly? Yes No If so, why? _____

For women: Are you pregnant? Yes No Date of last menstrual period: ____/____/____

HEALTH QUESTIONNAIRE - Page 2

Throughout life, stresses and traumatic events can damage the spine and nerve system. These stresses may be PHYSICAL, CHEMICAL and/or EMOTIONAL in nature. Understanding the PHYSICAL, CHEMICAL, and/or EMOTIONAL stresses that have acted upon your spine and nerve system assists us in serving you. We thank you in advance for answering the following questions as accurately and completely as possible.

HISTORY OF PHYSICAL STRESS (BIRTH TO PRESENT)

Research indicates that the birth process can cause trauma to a baby's spine and nerve system. Please indicate to the best of your recollection how you were birthed:

Was your birth: *(check all that apply)*

- Drug induced C section Breech Natural Forceps
 Vacuum extraction Prolonged Umbilical cord around neck Home Birth Hospital Birth

General Physical Trauma

Most traumas occur in the early years (between birth and the early twenties). It is during those years that your spine and nerve system is growing and most vulnerable. The information below will help us to consider the types of stresses that you have been subjected to.

Have you had any accidents related to the following: *(check all that apply)*

- Automobile Motorcycle Bicycle Sports Other: _____

If yes, please explain and give date(s): _____

Have you ever injured your nerve system or spine? (Head, neck, back, pelvis, hips): Yes No

If yes, please explain: _____

Have you broken any bones or sprained any part of your body? Yes No

If yes, please explain: _____

Have you ever had surgery or have you been hospitalized? Yes No

If yes, please explain: _____

HISTORY OF CHEMICAL STRESS

Chemical stresses occur during life due to any substance that is breathed, injected, taken orally, or placed on the skin that is toxic to the body. The following will give us insight into any exposures you may have had. *(Please check all that apply.)*

Have you been vaccinated? Yes No

Do you currently or have ever taken: Prescriptions drugs Over the counter drugs Recreational drugs

Have you been exposed to or currently exposed to? Chemicals Fumes Dust Smoke

Do you consume? Alcohol Coffee Caffeine Tobacco

HEALTH QUESTIONNAIRE - Page 3

HISTORY OF EMOTIONAL STRESS

It is difficult to separate the emotional stress in our lives from the physical response that often occurs. Please indicate if you have ever experienced any of the emotional stresses below:

(Please check all that apply.)

- | | | | | |
|---|---|------------------------------------|--|---|
| <input type="checkbox"/> Childhood trauma | <input type="checkbox"/> Loss of loved one | <input type="checkbox"/> Illness | <input type="checkbox"/> Relationships | <input type="checkbox"/> Family |
| <input type="checkbox"/> Work or School | <input type="checkbox"/> Divorce/Separation | <input type="checkbox"/> Financial | <input type="checkbox"/> Abuse | <input type="checkbox"/> Lifestyle change |
| <input type="checkbox"/> Parental Divorce | <input type="checkbox"/> Other _____ | | | |

QUALITY OF LIFE

- How do you grade your physical health? Good Fair Poor
- How do you grade your emotional/mental health? Good Fair Poor
- How do you rate your overall "quality of life"? Good Fair Poor

Please check the choice that most clearly describes your current goals for health and wellbeing:

- I am only concerned with my immediate problem.
- I am only concerned with my immediate problem and preventing its return.
- I want to achieve optimum function, health and well-being on every level that is available to me

FINANCIAL INFORMATION

Payment in full is expected on all FIRST VISIT services. All other fees are to be paid at the time of service unless other arrangements have been made and agreed upon in writing.

Please indicate your method of payment: Cash Check Credit card

If you have insurance, please indicate the type of policy and name of insurance carrier:

- Health Insurance Auto Accident Medicare Worker's Compensation

Name of Insurance Carrier: _____

Signature _____ Date ____/____/____

Signature of Parent (for minor): _____ Date ____/____/____

**Thank you for choosing Ehresman Family Chiropractic.
We are looking forward to helping you achieve wellness!**