NASHUA FAMILY CHIROPRACTIC

Brandon Linatsas, DC
Gabrielle Cohen, DC
Vicki Irwin, LAC
Candice Trudel, MS
Matthew Howard, LMT

29 Riverside Street, Unit B, Nashua, NH 03062 P: (603) 880-4150 F: (603) 880-6765

Welcome to Our Family! Your Health History is important to us. Please fill out this form COMPLETELY.		
Today's Date:		
Patient Title: ☐ Mr. ☐Mrs. ☐Ms. ☐Miss ☐Dr.		
First Name:	Last Name:	
Street Address:		
City:	State:	Zip Code:
Home #:	Cell #:	Work #:
How would you like your future appointment reminders? **☐Call ☐ Text ☐No Reminder** **Cell Phone Provider___________________________**		
Email:		
Date of Birth: / /	Age:	Sex: ☐Female ☐Male
Marital Status: ☐Single ☐Married	Spouse's Name:	
# of Children:	Are you/Is it possible you're pregnant? ☐ Yes ☐No	
Are you or your spouse trying to become pregnant? ☐Yes ☐ No		
Emergency Contact Name:	Relationship:	
Emergency Contact Phone #: ( )	Secondary #: ( )	
Primary Care Provider:	Phone: ( )	
Primary Care Provider Address:		
☐ Please do not share results of this visit with this provider		
Who may we thank for you referring you?		

Employment Status		
What is your job title/occupation?:		
☐Employed Full-Time	☐Employed Part-Time	☐Retired
☐Student	☐Work From/At Home	☐ Self- Employed
Employer Name:		

If you know your approximate height and weight please specify here	Height: ______'______"	Weight: __________lbs

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Why are you seeking chiropractic care? ☐Pain ☐Wellness ☐Nutrition/Lifestyle	
What is/are the area(s) of your complaint (s)?	
When did your symptoms start?	
Have you missed work due to this condition?	☐ No ☐ Yes How Long?
Is this condition due to a worker's compensation injury?	☐ No ☐ Yes
Is this condition due to an automobile accident?	☐ No ☐ Yes
Have you seen anyone else or received treatment for this condition?	☐ No ☐ Yes Whom?
Have you had any previous tests, x-rays, CT scans or MRI's previously taken?	☐No ☐ Yes What was done? Where?
Have you been to a chiropractor before?	☐ No ☐Yes Name:

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Please check the following boxes if you HAVE OR HAD any of the listed symptoms/conditions.

Cardiovascular	**Digestive**	**Endocrine**	**Integumentary**
☐No issues	☐No issues	☐No issues	☐ No issues
☐High blood pressure	☐Reflux/Heartburn	☐Thyroid Issues	☐Skin Cancer
☐Low Blood Pressure	☐Ulcer	☐Immune Disorders	☐Psoriasis
☐High Cholesterol	☐Constipation	☐Frequent Infections	☐Eczema
☐Poor Circulation	☐Diarrhea	☐Hypoglycemic	☐Acne
☐Fainting	☐Food Sensitivities	☐Diabetic Type I ☐ Type II ☐	☐Rash
☐Angina/Chest pain	☐Anorexia/Bulimia	☐Swollen/hard glands	☐Other
☐Excessive Bruising	☐Poor appetite	☐Low Energy	
☐Palpitations	☐Other	☐High stress	
☐Other		☐Low Libido	
		☐Fatigue	
		☐Other	
Genitourinary	**Musculoskeletal**	**Neurological**	**Respiratory**
☐No issues	☐No issues	☐No issues	☐No issues
☐Kidney Stones	☐Upper back Pain	☐Sciatica	☐Asthma
☐Prostate Issues	☐Mid-back Pain	☐Pins and Needles	☐Apnea
☐Erectile dysfunction	☐Low back Pain	☐Numbness	☐Persistent cough
☐Bedwetting	☐Neck Pain/Stiffness	☐Dizziness	☐Difficulty breathing
☐Recurrent UTI	☐Headaches	☐Tremors	☐Hay fever
☐Infertility	☐Migraines	☐Blurred Vision	☐Emphysema
☐Ovarian Cysts	☐Osteoporosis	☐Carpal Tunnel	☐Pneumonia
☐PMS symptoms	☐Arthritis	☐ Anxiety	☐Bronchitis
☐Other	☐Arm/hand pain	☐Depression	☐Other
	☐Shoulder problems	☐Irritability	
	☐Plantar Fasciitis	☐Visual Disturbances	
	☐Foot/ankle pain	☐Loss of balance	

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	☐Leg pain	☐Blurred Vision	
	☐Hip problems	☐Loss of taste	
	☐TMJ issues	☐Loss of smell	
	☐Scoliosis	☐Bell's Palsy	
	☐Poor Posture	☐Loss of hearing	
	☐Other	☐PTSD	
		☐Other	

Health History		
Current Medications: Please list all prescriptions, over-the-counter medicines and dietary supplements. If possible, include the brand name for supplements. If NO current medications please check here ☐		
Medication/Supplement	Dose	Frequency
1.		
2.		
3.		
4.		
5.		
6.		

Please list any known allergies you may have. If no known allergies, check here ☐	
1.	2.
3.	4.

Do you use tobacco of any type? ☐Yes ☐No ☐ Former tobacco user ☐Never used tobacco

If Yes, how often do you use tobacco? How much?

Are you interested in quitting? ☐Yes ☐No

Are there any past or current medical conditions you have not told us about?

Please date/list reasons for any hospitalizations or surgical procedures.

Date	Reason

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Please describe any other injuries/accidents not mentioned previously.	
Date	**Injury**

Family History Please include any pertinent, immediate family medical histories (Diabetes, hypertension, cardiac arrest, stroke, cancer, rheumatoid arthritis etc.)	

Lifestyle Habits										
On a scale of 0-10 (0 being NO stress, 10 being A LOT of stress), please indicate your level of stress:										
☐0	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8	☐	☐10

How much and how often do you drink alcohol?	#_______Drinks, ☐Daily ☐Weekly ☐Monthly
How many cups of coffee/caffeine do you drink daily?	#_________ Cups
How much soda do you consume daily?	#_________Cups
How much water do you drink daily	#_________Cups
Do you use recreational drugs?	☐Yes ☐No

Please rate your healthy eating habits, where 0 means your habits are unhealthy and 10 means your habits are very healthy.										
☐0	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8	☐9	☐10

What are you typical eating habits, check all that apply			
☐ Skip Breakfast	☐ 2 meals a day	☐ 3 meals a day	☐ Snacking between meals

On average how many hours do you sleep at night?	
What is your preferred sleeping position	
On a regular basis how much do you exercise?	
What type of exercise do you do?	
What is the most significant thing you could do to improve your health?	

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What is something that makes you happy?

Patient Signature:_______________________________________ **Date:** _________________