

**Serengeti Natural Healing and Chiropractic Center
Health Case History**

Name _____ Sex: M F Date _____

Address _____ City _____ Zip _____

H. Phone (____) _____ W. Phone (____) _____ Cell Phone (____) _____

E-mail Address: _____ Date of Birth _____ Age _____ S M D W

Occupation _____ Employer _____

Please let us know how/who referred you to our office: _____

Have you ever received Chiropractic Care? Yes No

If yes please explain: _____

Have you ever received Nutritional Counseling? Yes No

If yes please explain: _____

Reasons for seeking health care services:

Primary reason: _____

Secondary reason: _____

Social and Occupational History:

Level of Education:

High School Some College College Graduate Post Graduate Studies

Job description: _____

Work schedule: _____

Recreational activities: _____

Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet): _____

Patient Name: _____

Females Only – Date of last menstrual period _____ Could you be pregnant? _____

Pregnancies and outcomes:

Previous major illnesses:

Previous injuries or trauma: _____

Have you ever broken any bones? Which? When? _____

Allergies: _____

Surgeries: _____

How do you rate your Physical health? (please circle)

Excellent Good Fair Poor Getting Better Getting Worse

Compared to 5 years ago, are you now: Not as healthy As Healthy Healthier

What strategies have you used to improve your health:

Family Health History:

Is there a family History of:

	Heart Disease	Arthriti	Cancer	Diabetes	Other	Deceased
Father's side	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> _____	<input type="radio"/> When _____ Cause _____
Mother's side	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> _____	<input type="radio"/> When _____ Cause _____

Bio-Chemical Health:

Current Medications:

Please list ALL drugs you currently take or have taken in the past 6 months: (attach form if needed)

Name: _____ Dosage _____ For What? _____

Name: _____ Dosage _____ For What? _____

Name: _____ Dosage _____ For What? _____

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Name: _____ Dosage _____ For What? _____

Name: _____ Dosage _____ For What? _____

Name: _____ Dosage _____ For What? _____

Name: _____ Dosage _____ For What? _____

Patient name: _____

Nutritional Assessment:

Current Supplements:

Please list ALL nutritional supplements, vitamins, homeopathic remedies you presently take:

Name: _____	Dosage _____	For What? _____
Name: _____	Dosage _____	For What? _____
Name: _____	Dosage _____	For What? _____
Name: _____	Dosage _____	For What? _____
Name: _____	Dosage _____	For What? _____
Name: _____	Dosage _____	For What? _____
Name: _____	Dosage _____	For What? _____
Name: _____	Dosage _____	For What? _____

Diet:

Please circle any dietary selection that is appropriate for you, and grade according to the following scale:

Daily:

D -Consume this daily
FD -Consume this a few times per day

Monthly:

M -Consume this monthly
FM -Consume this a few times per month

Weekly:

W -Consume this weekly
FW -Consume this a few time per week

Never:

N -Never consume this

Alcohol _____	Eggs _____	Fasting _____	Fruit _____
Tobacco _____	Fish _____	Diet Food _____	Organic Foods _____
Coffee _____	Beef _____	Weight Control Diet _____	Raw Vegetables _____
Soda _____	Poultry _____	Artificial Sweetener _____	Whole Grains _____
Fried Foods _____	Seafood _____	Cooked Vegetables _____	Canned Veg. _____
Refined Sugar _____	Dairy _____		