Dr. Ray Rickards

Scientific Chiropractic, Fitness and Anti-Aging Center

HEALTH HISTORY

Name: _____ DOB: ____ /____ /_____
Address: _____
City/State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____
Work Phone: _____ Email: _____
Occupation: _____ Employer: _____
Spouse: _____ Children (name/age): _____
_____

Who Referred You to Us? _____
Reason for Consulting Our Office: _____
_____
Past Chiropractic Care? YES / NO Date of Last Visit: _____
Name/Location: _____
Current Medical Care? YES / NO Why? _____
Current Drugs/Medications: _____
_____

PLEASE CHECK THE ONE CHOICE THAT MOST CLOSELY DESCRIBES YOUR CURRENT GOALS FOR HEALTH/WELLBEING.

☐ I am only concerned about relief of a particular symptom
☐ I am only concerned about relief of a particular symptom, and preventing its return
☐ I want optimum health and wellbeing on every level available to me

PLEASE CHECK ALL THAT APPLY:

☐ MEDICARE

☐ AUTO ACCIDENT DATE OF INJURY: _____

WE ACCPT PAYMENT BY CASH, CHECK AND CREDIT CARD

I understand that all services are to be paid in full at the time of service, unless other arrangements have been made and agreed upon in writing.

Signature_____ Date_____

PLEASE TELL US ABOUT ANY STRESS AT YOUR BIRTH:

__ Drugs/medicine/tobacco/alcohol in pregnancy Explain:_____
__ Labor chemically induced? _____
__ Forceps/Vacuum Extraction/C-section _____
__ Premature delivery? _____
__ Vaccinations? _____
__ Falls in first year of life? _____
__ Any health related problems? _____

PLEASE TELL US ABOUT ANY STRESS ASSOCIATED WITH CHILDHOOD:

__ Any falls or injuries? Explain: _____
__ Allergy/Asthma or Respiratory problems? _____
__ Ear infections? _____
__ Digestive problems? _____
__ Hyperactivity? _____
__ Any other health related problems? _____

PLEASE TELL US ABOUT ANY STRESS UP TO PRESENT:

__Auto Accident or Injury? Explain: _____
__Work Injury? _____
__ Sports Injury? _____
__ Work Stress? _____
__ Family/Home Stress? _____
__ Prescription Drug Use? _____
__ Non-Prescription Drug Use? _____
__ Ever Hospitalized? _____
__ Surgery? _____
__ Any Major Illness? _____
__ Limited Exercise? _____
__ Poor Nutrition? _____

Comments:_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____