Health History

Name: _____ Date: _____

Date of Birth: _____ Age: _____ Gender: ☐ Male ☐ Female

Mailing Address: _____ City: _____

State: ____ Zip: _____ Home Phone: _____ Cell Phone: _____

Email: _____

Occupation: _____ Do you primarily: ☐ Sit ☐ Stand ☐ Perform repetitive tasks

Height (ft): _____ Weight (lbs): _____

Marital Status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

How many children: ____ Ages: _____

How did you hear about Plaisance Chiropractic? _____

How do you prefer to be contacted? ☐ Home Phone ☐ Cell Phone ☐ Text ☐ Email

QUESTIONNAIRE:

What are your three most important current health concerns?

1. _____
2. _____
3. _____

List any medical problems currently being managed by a physician: _____

_____

List any hospital stays and/or surgeries with dates: _____

_____

Have you been diagnosed with any clinical condition or disease? ☐ No ☐ Yes

If yes, what: _____

Have you ever been in a motor vehicle accident? ☐ No ☐ Yes

If yes, what kind and when: _____

Were you evaluated and treated after each accident? ☐ No ☐ Yes

Have you had any non-vehicle accidents or falls? ☐ No ☐ Yes

If yes, please explain: _____

Have you had any imaging performed in the last year? ☐ No ☐ X-ray ☐ MRI ☐ US ☐ PET

Have you had blood work performed in the last year? ☐ No ☐ Yes

Were your test results in medically normal ranges? ☐ No ☐ Yes

If not, which results were abnormal? _____

GENERAL LIFESTYLE:

What is your activity level on a scale from 1-10? (10 being very active) _____

What is your average energy level on a scale of 1-10 (10 being the optimal energy level you think you *should* have)? _____

On average, how many hours do you sleep per night?

Do you feel you get adequate sleep? ☐ Yes ☐ No _____

Do you wake rested? ☐ Yes ☐ No _____

Do you wake during the night? At what time? ☐ Yes ☐ No _____

Do you sleep next to any electronic devices? ☐ Yes ☐ No _____

Do you exercise? ☐ Yes ☐ No _____

Do you follow any particular diet? ☐ Yes ☐ No _____

Do you consume caffeine daily? ☐ Yes ☐ No _____

Do you use tobacco? ☐ Yes ☐ No _____

Do you consume alcohol? ☐ Yes ☐ No _____

Do you feel you've ever had a problem with overuse of drugs or alcohol? ☐ Yes ☐ No

_____

SHAPE RECLAIMED

What health benefits do you want to achieve with the SHAPE Reclaimed program?

☐ Improved eating habits ☐ Improved well-being ☐ Decreased inflammation ☐ Weight reduction

☐ Increased energy ☐ Improved sleep ☐ Increased stamina ☐ Other _____

Have you tried SHAPE Reclaimed before? If so, when? _____

What was/wasn't successful? _____

What other programs have you tried? _____

What was/wasn't successful? How long did it take to gain the weight back? _____

_____

Please state specifically what you goals have with this program: _____

_____

MENTAL/EMOTIONAL HEALTH

Do you have a good support system? ☐ Yes ☐ No _____

Do you have a spiritual practice? ☐ Yes ☐ No _____

What are the main stresses in your life? _____

Have you experienced any particularly life-changing stressful events? _____

_____

What do you do to de-stress? _____

What are your some of your hobbies? _____

Rate the current level of **personal stress** in your life: ☐ None ☐ Low ☐ Moderate ☐ High

Rate the current level of **relationship stress** in your life: ☐ None ☐ Low ☐ Moderate ☐ High Rate the current level of **health stress** in your life: ☐ None ☐ Low ☐ Moderate ☐ High

Rate the current level of **family stress** in your life: ☐ None ☐ Low ☐ Moderate ☐ High

Rate the current level of **occupational stress** in your life: ☐ None ☐ Low ☐ Moderate ☐ High

How do you manage the stress in your life? _____

CHEMICAL HEALTH

Do you choose to get annual flu shots? ☐ No ☐ Yes

Have you used antibiotics in the last year? ☐ No ☐ Yes

How many cups of water do you drink per day? ☐ 0 ☐ 1-3 ☐ 4-6 ☐ 7-9 ☐ 10+

How many cups of coffee/energy drinks do you drink per day? ☐ 0 ☐ 1-3 ☐ 4-6 ☐ 7-9 ☐ 10+

How many glasses of juice/soda/sports drinks do you drink per day? ☐ 0 ☐ 1-3 ☐ 4-6 ☐ 7-9 ☐ 10+

Do you eat wheat products (bread/pasta/crackers/baked goods)? ☐ No ☐ Yes

If yes, how many servings per day? _____

Do you eat refined sugar? ☐ No ☐ Yes

If yes, how many servings per day?_____

Do you ingest artificial sweeteners (Splenda, Aspartame, Equal, diet drinks, gum)? ☐ No ☐ Yes

Do you have any food/drink allergies, sensitivities or intolerances? ☐ No ☐ Yes: _____

Do you smoke? ☐ No ☐ Yes ☐ I used it for: _____ years

Are you/have you been exposed to second-hand smoke? ☐ No ☐ Yes

Do you take probiotics? ☐ No ☐ Yes

Do you take Vitamin D? ☐ No ☐ Yes

Do you take Omega-3? ☐ No ☐ Yes

Other supplements or homeopathics: _____

Please list any medications (prescription &/or over the counter) that you take regularly and why:

_____

_____

FOOD HEALTH

Please list the foods you commonly eat for:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks:_____

How many cups of vegetables do you eat per day? ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7+

What foods do you crave? _____

SYMPTOMS: Please check the boxes of symptoms that you are currently experiencing, or have experienced in the past 6 months:

Women:

☐ Breast masses ☐ Lack of periods (premenopause) ☐ Menopause (age) _____

☐ Hysterectomy ☐ Painful/Heavy periods ☐ Vaginal discharge

☐ Irregular periods ☐ Spotting ☐ Yeast infections

☐ Pregnancies #_____ ☐ Miscarriage #/date _____ ☐ C-section #_____

Are you/Do you plan to become pregnant? ☐ Yes ☐ No _____

Are you breastfeeding? ☐ Yes ☐ No _____

Are you taking birth control? What kind? ☐ Yes ☐ No _____

Are you on hormone replacement therapy? ☐ Yes ☐ No _____

Other:

☐ Autoimmune disease ☐ Hernia ☐ Relationship problems

☐ Bleeding gums ☐ History of abuse ☐ Restless legs

☐ Employment difficulties ☐ History of antibiotic use ☐ Schizophrenia

☐ Erectile dysfunction ☐ History of vaccine reactions ☐ Serious head injury

Bowel Movements/day _____

Notes:

_____

_____

BLOOD WORK:

If you have recent blood work (within the last 6 months), please include a copy with this form. It is not required, but can be extremely helpful in understanding your full health picture.

SHAPE RECLAIMED INFORMED CONSENT:

***I* _____, understand that SHAPE Reclaimed is a lifestyle modification, health transformation program designed to help me improve my overall health. This program is not intended to replace the guidance of my primary health care experts. While this program is not used to diagnose, treat, cure or prevent any disease, I understand any medications I am currently taking may need dosage adjustment. I agree to notify my prescribing physician that I am working with Dr. Denise Plaisance, DC PC and will be closely monitored while incorporating this program embracing a healthier lifestyle. I understand an anti-inflammatory nutritional regimen will be recommended based on my unique health history, urinalysis, and symptoms. I hereby grant permission to receive a professional consultation, including urinalysis and evaluation.**

Signature: _____ Date: _____

FINANCIAL AGREEMENT:

I, _____, agree to full financial responsibility for services rendered and products purchased. I understand that payment is required in full prior to service or purchase unless arrangements were agreed to in advance. Cash, check and Charge are the only accepted forms of payment at this time. Notice of 24 hours is necessary for cancelled appointments. I may be charged full price for a missed appointment. We reserve the right to require prepayment to reschedule your next appointment. This advance payment will be applied to your next appointment.

Signature (patient/parent/guardian):

_____ Date:_____

Fee is patients' responsibility and will not be covered by insurance or liabilities.