# Helios Center Personal History Questionnaire

Date_____

Name:_____

Address:_____

City:_____ State:_____Zip:_____

Occupation:_____ Home Phone:_____ Business Phone:_____

E-mail: _____

Date of Birth:_____ Age:_____ θ M θ F Marital Status: _____ No. of Children:_____

How did you hear of our office:_____

Please answer the following questions about your Personal History:

1. Have you ever had your spine or nervous system examined by a chiropractor or medical doctor? θ Yes θ No
   If yes, when & by whom:_____
   Were you satisfied with the results of your care? θ No θ Yes Why? _____
   _____
   Are you receiving any other forms of health care? _____
   i.e. Massage, Meditation, Yoga, Therapy, etc.
2. What brings you here today?_____
   _____
   _____
3. What do you hope to receive from care in this office?_____
   _____
   _____

General Physical Events:

Have you ever:

| | | |
|---|---|---|
| Been knocked unconscious? | θ No | θ Yes, when:_____ |
| Used crutches, a walker or cane? | θ No | θ Yes, when:_____ |
| Broken any bones? | θ No | θ Yes, when:_____ |
| Have you ever been involved in a vehicular collision or near collision?(Even if you do not think you were hurt.) | θ No | θ Yes, when:_____ |
| Fallen from horses, trees, other? | θ No | θ Yes, when: _____ |

If yes to any of the above, please describe:_____
_____
_____

Birth Events: Are you aware of any unusual circumstances surrounding your birth? θ No θ Yes, please describe:
_____

_____

Work Position: During the workday do you? stand_____ walk_____sit_____ drive_____bend, turn_____
lift_____ lbs_____

Sports or Leisure: Do you exercise? θ No θ Yes, please describe:_____
_____

Sleep Patterns: Number of hours per night? _____

Do you feel you get enough sleep? θ Yes θNo

Do you feel rested? θ Yes θNo

**Please complete both sides**

## Medical Intervention:

Have you ever:

Been hospitalized? θ No θ Yes, when:_____

Had surgery? θ No θ Yes, when:_____

If yes to any of the above, please describe:_____

_____

_____

_____

## Chemical History:

Are you currently:

| | | | | | |
|---|---|---|---|---|---|
| Taking any supplements? | θYes | θ No | Tobacco? | θYes | θ No |
| Taking any medications? | θ Yes | θ No | Coffee? | θYes | θ No |
| Being exposed to chemicals? | θ Yes | θNo | Artificial sweeteners? | θYes | θ No |
| Alcohol? | θ Yes | θ No | Soda pop? | θYes | θ No |

If yes to any of the above, please describe:_____

_____

_____

How would you describe your general diet? (Ex: Some red meat; Lots of veggies, etc.)_____

_____

_____

## Life events:

Please describe your past or current life events? (i.e. Death in family, work concerns, major health issues, etc)

_____

_____

_____

If you consider yourself well, why do you feel well? _____

_____

If you consider yourelf ill, why do you feel ill?_____

_____

Is there anything else you may wish to share which may help us to better understand you?

_____

_____

Why you have chosen to come here for care?

_____

_____