# Move Better Chiropractic & Fitness

**1400 Peoples Plaza Suite224 Newark DE 19702 (302) 836-6443**

**PERSONAL HELATH HISTORY**

Please allow our staff to photocopy your driver's license

Name: _____ Date: _____

Name Of Person Legally Responsible (if client is a minor): _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Home: _____ Business: _____ Cell: _____

Birth Date: _____ Gender: O Male O Female Height: _____ Weight: _____

E-mail Address: _____

Check One: O Single O Partner O Married O Separated O Divorced O Widowed No. of Children: _____

Spouse's Name: _____ Females: Are You Pregnant? O Yes O No

Emergency Contact: _____ Phone: _____

How Did You Hear About Us: _____

Business/Employer: _____ Type Of Work: _____

Activity Level At Your Job: O None (mostly seated) O Moderate (light activity) O Heavy (heavy labor, very active)

Any Shift Work: O Yes O No Travel: O Rarely O Few Times Per Year O Few Times Per Month O Weekly

How Are You Doing Today: Awful 1 O O O O O O O O O O 10 Great Notes:

What Are Your Health And Fitness Goals: _____

_____

_____

Do You Have A Specific Time For Achieving These Goals: _____

_____

_____

Athletic Hobbies Or Activities: _____

_____

_____

Special Diet Or Exercise Plan: _____

_____

_____

Do You Consider Yourself: O Underweight O About Right O Overweight

Any Unintentional Weight Gain Or Loss Of 10 Pounds Or More In The Past 3 Months: _____

_____

Days You Can Commit To Training: O Monday O Tuesday O Wednesday O Thursday O Friday O Saturday

Does Anything Hurt: _____ Notes:

_____

_____

How Did It Start: O Accident or Injury O Work O Auto O Worsening of Long Term Problem

O Other _____

When Did Symptoms First Start: _____

Describe How It Feels: _____

_____

When Do You Feel It: O Constantly O Comes & Goes O First Thing In The Morning O Later In The Day

O At Night O Other _____

What Makes It Worse: _____

What Makes It Better: _____

Other Treatments Tried For These Symptoms: _____

_____

_____

How Does This Interfere With Your Life: _____

_____

_____

Any Other Health Concerns: _____

_____

_____

List All Medications Or Vitamins Currently Using: _____

_____

_____

Approximate Dates Of Any Surgeries, Serious Illness, Accidents, Or Broken Bones: _____

_____

_____

Acknowledgments: Please read each statement and initial your agreement.

_____ I understand the program offered in this office is based on the latest available evidence and does not proclaim to cure or treat any named disease or entity.

_____ I recognize that it is my responsibility to work directly with my physician before, during and after seeking fitness consultation.

_____ I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf.

_____ I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, e-mail or health information as an extension of my care in this office.

_____ I understand that any insurance I may have is an agreement between the carrier and myself and that I am fully responsible for payment of all services I receive.

_____ _____

Signature Of Client Or Legally Responsible Party Date