Health History

Patient name: _____ Date: _____

Date of Birth: _____ Email: _____

Address: _____ City/State/Zip: _____

Driver's License #_____ State issued: _____

Sex: ☐ M ☐ F ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated

Occupation: _____ Employer: _____

Spouses Name: _____ Spouses occupation: _____

Children: _____

Who may we thank for referring you? _____

Phone number: Cell _____ Home _____

Emergency Contact: _____ Phone # _____

Relationship to patient: _____

Reason for visit: _____

Is this due to an accident? ☐ Yes ☐ No If yes, what kind?: ☐ Auto ☐ Work related ☐ Home

Has it been reported to: ☐ Insurance company ☐ Employer ☐ Work Comp

When did the symptoms appear? _____ Is the condition getting worse? ☐ Yes ☐ No

How often do you have this pain? _____ Pain: ☐ is constant ☐ comes and goes

Does it interfere with: ☐ Work ☐ Sleep ☐ Recreation ☐ Daily routine ☐ _____

Are the following painful or difficult? ☐ Sitting ☐ Standing ☐ Walking ☐ Lying ☐ Bending ☐ Lifting ☐

Other _____

Rate your pain from 1-10 _____

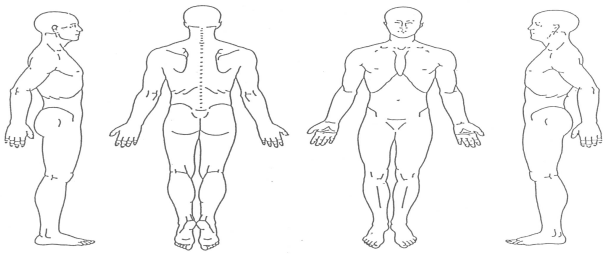
Do you feel the following?:

☐ Numbness ☐ Tingling ☐ Weakness

☐ Sharp ☐ Dull ☐ Ache ☐ Throbbing

☐ Burning ☐ Swelling ☐ Stiffness ☐ Cramps

Using the drawing below, where do you feel the pain?



How does your condition make you feel? _____

What would you be able to do/enjoy that you can't currently if this condition was gone?

_____

Have you been treated for this condition previously? ☐ Yes ☐ No If yes, please check all that apply:

☐ Medication ☐ Surgery ☐ Chiropractic ☐ Nutrition ☐ Acupuncture ☐ Other _____

Date of last exam: Physical _____ Blood work _____ Urine _____

X-Rays_____ MRI/CT/Ultrasound _____

Have you had or currently have any on the following:

AIDS	☐ Yes ☐ No	Alcoholism	☐ Yes ☐ No	Allergy shots	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Anorexia	☐ Yes ☐ No	Appendicitis	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Asthma	☐ Yes ☐ No	Autoimmune	☐ Yes ☐ No
Bleeding disorder	☐ Yes ☐ No	↑ Blood pressure	☐ Yes ☐ No	Breast lump	☐ Yes ☐ No
Bronchitis	☐ Yes ☐ No	Bulimia	☐ Yes ☐ No	Cancer	☐ Yes ☐ No
Cataracts	☐ Yes ☐ No	Chemical	☐ Yes ☐ No	Chicken pox	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Dependency		Emphysema	☐ Yes ☐ No
Epilepsy	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Goiter	☐ Yes ☐ No
Gout	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No
Hernia	☐ Yes ☐ No	Herniated Disc	☐ Yes ☐ No	Herpes	☐ Yes ☐ No
High Cholesterol	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No
Measles	☐ Yes ☐ No	Miscarriage	☐ Yes ☐ No	Mumps	☐ Yes ☐ No
Mononucleosis	☐ Yes ☐ No	Multiple Sclerosis	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No
Pacemaker	☐ Yes ☐ No	Parkinson's	☐ Yes ☐ No	Pinched nerve	☐ Yes ☐ No
Pneumonia	☐ Yes ☐ No	Prostate problem	☐ Yes ☐ No	Polio	☐ Yes ☐ No
Prosthesis	☐ Yes ☐ No	Psychiatric care	☐ Yes ☐ No	Scarlet fever	☐ Yes ☐ No
Rheumatoid	☐ Yes ☐ No	Rheumatic fever	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Arthritis		Suicide attempt	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Thyroid Problem	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No	Tumors	☐ Yes ☐ No
Typhoid fever	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No	Vaginal	☐ Yes ☐ No
Venereal disease	☐ Yes ☐ No	Whooping cough	☐ Yes ☐ No	Infections	

Other: _____

Do you get headaches? ☐ Yes ☐ No How often?_____

How would you describe them? ☐ Migraine ☐ Visual disturbance ☐ Nausea ☐ Tension ☐ Vomiting
☐ Aura ☐ Light sensitive ☐ Related to allergies ☐ Ocular migraine

Are you pregnant? ☐ Yes ☐ No Due Date_____

Have you ever taken antibiotics? ☐ Yes ☐ No Are you taking birth control? ☐ Yes ☐ No

Have you used hormone replacement? ☐ Yes ☐ No

Are you Vegetarian? ☐ Yes ☐ No Do you skip meals? ☐ Yes ☐ No

Amount of sugar you eat? ☐ Low ☐ Moderate ☐ High Do you crave sugar? ☐ Yes ☐ No

Do you smoke? _____ How many years?_____ How many times a day?_____, a week? _____

Have you ever smoked?_____ How many years? _____ When did you quit?_____

Falls_____ Date _____

Head injuries_____ Date _____

Broken Bones_____ Date _____

Auto Accidents_____ Date _____

Surgeries_____ Date _____