For Office Use Only:
Past DC: Y N
S M D W
City: ________
Ref by: __________

Health History

Date: ________________

Name: ________________________________ Age: _________

Employer: _____________________________ Occupation: ______________________

Reason for seeking Chiropractic Care:

Major Complaints and Symptoms:

____

____

When did you first notice this? _________________ Has this happened before? Yes ◻ No ◻

If yes, when? _______________________ Any family history of this condition? Yes ◻ No ◻

Does this interfere with normal living and/or work? Yes ◻ No ◻

Was it caused by a: (circle one) Strain ◻ Fall ◻ Accident ◻ Emotional Shock ◻

Have you had treatment by another doctor for this? Yes ◻ No ◻ By: MD ◻ Chiropractor ◻

Name of Doctor: ____________________ Diagnosis: _______________________

What type of treatment did you receive? __________________________________

Length of time under doctor's care: ____________ Results: __________________

HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES? (*Please check)*

◻ Polio	◻ Lumbago	◻ Appendicitis	◻ Heart Disease	◻ Anemia	◻ Sciatica
◻ Alcoholism	◻ Scarlet Fever	◻ Measles	◻ Epilepsy	◻ Tuberculosis	◻ Typhoid Fever
◻ Mumps	◻ Diabetes	◻ Chicken Pox	◻ Rheumatic Fever	◻ Cancer	◻ Pleurisy
◻ Pneumonia	◻ Venereal Infection	◻ Goiter	◻ Malaria	◻ Rheumatism	◻ Mental Disorders
◻ Flu	◻ Small Pox	◻ Diphtheria	◻ Whooping Cough	◻ Cholera	◻ Arthritis

OPERATIONS: _____None, or:

Date _____________ Tonsillectomy Date ______________ Appendectomy Date ___________Hernia

Date _____________ Gall Bladder Date ______________ Female Organs Date ___________Thyroid

Date _____________ Back or Neck Date ______________ Colon / Rectum Date ___________Stomach

Date _____________ Heart Date ______________ Knee/Leg/Ankle Date ___________Wrist/Arm

Date _____________ Sinus Date ______________ Skin Date ___________Shoulder

Others not listed above (with date): ____

Please check all of the following symptoms and signs which you now have or have had within the last 6 months. An understanding of your health status will help facilitate care.

GENERAL SYMPTOMS:

- □ Headache
- □ Fever
- □ Chills
- □ Night Sweats
- □ Fainting
- □ Dizziness
- □ Convulsions
- □ Loss of sleep
- □ Loss of weight
- □ Numbness or pain in arms, legs or hands
- □ Allergy (what)
- □ Wheezing
- □ Neuralgia
- □ Fatigue

MUSCLE & JOINTS

- □ Weakness
- □ Twitching
- □ Stiff neck
- □ Backache
- □ Swollen joints
- □ Tremors
- □ Foot trouble
- □ Painful tail bone
- □ Pain between shoulders
- □ Hernia
- □ Spinal curvature

GASTRO-INTESTINAL:

- □ Poor appetite
- □ Poor digestion
- □ Excessive hunger
- □ Belching or gas
- □ Nausea
- □ Vomiting
- □ Vomiting blood
- □ Pain over stomach
- □ Constipation
- □ Diarrhea
- □ Colon trouble
- □ Hemorrhoids (piles)
- □ Gall Bladder trouble
- □ Regular bowel movement
- □ Jaundice

CARDIO-VASCULAR

- □ Rapid heart
- □ Slow heart
- □ High blood pressure
- □ Low blood pressure
- □ Pain over heart
- □ Previous heart trouble
- □ Swelling of ankles
- □ Poor circulation
- □ Varicose veins
- □ Strokes

EYE, EAR, NOSE, THROAT:

- □ Poor vision
- □ Crossed eyes
- □ Pain in eyes
- □ Deafness
- □ Earache
- □ Ear noises
- □ Nasal obstruction
- □ Nose bleeds
- □ Sore throat
- □ Hoarseness
- □ Hay fever
- □ Enlarged thyroid
- □ Frequent colds
- □ Tonsillitis
- □ Sinus Trouble

SKIN OR ALLERGIES

- □ Skin eruptions
- □ Itching
- □ Bruising easily
- □ Dryness
- □ Boils
- □ Sensitive skin
- □ Hives or allergies
- □ Eczema
- □ Medicines

EXERCISE:

□None □Moderate □Daily

RESPIRATORY:

- □ Chronic cough
- □ Spitting blood
- □ Spitting phlegm
- □ Chest pain
- □ Difficulty breathing
- □ Bronchitis

GENITO-URINARY

- □ Frequent urination
- □ Painful urination
- □ Blood in urine
- □ Kidney infection
- □ Bed wetting
- □ Inability to control urine
- □ Prostate trouble

FOR WOMEN ONLY

- □ Painful periods
- □ Excessive Flow
- □ Irregular cycles
- □ Hot flashes
- □ Cramps or backache
- □ Miscarriages
- □ Vaginal discharge
- □ Pregnant at this time

HABITS

- □ Smoking__packs per day
- □ Drinking __Alcohol
- □ Coffee __ cups per day

LIST ANY ACCIDENTS OR FALLS (even if minor, or not your fault, or long ago, or as a child):_______________

____

____

BROKEN BONES OR DISLOCATIONS (FRACTURES): ______________________________________

____

Have you ever had any epidurals or spinal injections? Yes □ No □   Were you ever knocked unconscious? Yes □ No □

Have you ever had X-Rays taken? ______ If so, when? _________ By Whom? ___________________________

For what ailments were these pictures made? ____

Do you suffer from any condition other than that which you are now consulting us? ___________________

____

Are you presently taking any medications, vitamins or herbs? (this includes Advil, Aspirin, Tylenol, etc) Yes □ No □

If so, what ones? ____

For which conditions? ____

I affirm that that the information provided here is accurate and true.

_______________________________   _______________________________

Signature   Date