

PATIENT HEALTH HISTORY

Have you ever seen a chiropractor before? Yes _____ No _____

What treatment have you already received for your condition?

Medication _____ Surgery _____ Physical Therapy _____ Chiropractic Services _____ None _____
Other _____

Name of doctor(s) who have treated you for your condition:

Please enter: "2" (Previously), "3" (Presently) in front of all of the following signs and symptoms. If not applicable, put NA. A complete history and understanding of your health will facilitate care. Behind condition, put number of times per month condition occurs.

GENERAL SYMPTOMS

- _____ Headache
- _____ Fever
- _____ Chills
- _____ Night Sweats
- _____ Fainting
- _____ Dizziness
- _____ Convulsions
- _____ Loss of Sleep
- _____ Fatigue
- _____ Nervousness
- _____ Loss of Weight
- _____ Numbness or pain
in arms/legs/hands
- _____ Wheezing
- _____ Neuralgia

MUSCLES & JOINTS

- _____ Weakness
- _____ Twitching
- _____ Stiff Neck
- _____ Backache
- _____ Swollen Joints
- _____ Tremors
- _____ Foot Trouble
- _____ Painful Tail Bone
- _____ Pain between
Shoulders
- _____ Spinal Curvature

HABITS

- Smoking Packs/Day _____
- Alcohol Cups/Day _____
- Coffee Cups/Day _____
- Caffeine Cups/Day _____

GASTRO-INTESTINAL

- _____ Poor Appetite
- _____ Poor Digestion
- _____ Starvation
- _____ Belching / Gas
- _____ Nausea
- _____ Vomiting
- _____ Vomiting Blood
- _____ Pain over Stomach
- _____ Constipation
- _____ Diarrhea
- _____ Colon Trouble
- _____ Hemorrhoids (piles)
- _____ Fluid Retention
- _____ Liver Trouble
- _____ Gout
- _____ Jaundice
- _____ Gall Bladder Trouble

CARDIO-VASCULAR

- _____ Rapid Heart
- _____ Slow Heart
- _____ High Blood Pressure
- _____ Low Blood Pressure
- _____ Pain over Heart
- _____ Heart Trouble
- _____ Swelling Ankles
- _____ Poor circulation
- _____ Varicose Veins
- _____ Strokes
- _____ Palpitations

EXERCISE

- None
- Moderate
- Daily
- Type _____

EYE/EAR/NOSE/THROAT

- _____ Poor Vision
- _____ Crossed Eyes
- _____ Pain in Eyes
- _____ Deafness
- _____ Earache
- _____ Ear Noises
- _____ Ear Discharges
- _____ Nasal Obstruction
- _____ Nose Bleeds
- _____ Sore Throats
- _____ Hoarseness
- _____ Hay Fever
- _____ Asthma
- _____ Frequent Colds
- _____ Enlarged Thyroid
- _____ Tonsillitis
- _____ Sinus Trouble

SKIN OR ALLERGIES

- _____ Skin Eruptions
- _____ Itching
- _____ Bruising Easily
- _____ Dryness
- _____ Boils
- _____ Sensitive Skin
- _____ Hives or Allergy
- _____ Eczema

RESPIRATORY

- _____ Chronic Cough

- _____ Spitting Blood
- _____ Spitting Phlegm
- _____ Chest Pain
- _____ Difficulty Breathing

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 Cycle
- _____ Hot Flashes
- _____ Cramps or Backaches
- _____ Vaginal Discharge
- _____ Pregnant at this time
- _____ Last Pap

By Whom _____

Other _____

HAVE YOU HAD ANY OF THE FOLLOWING:

- | | | |
|---------------------------------------|--|--|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Low back pain |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Goiter | <input type="checkbox"/> Mental Disorder |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> HIV | <input type="checkbox"/> Pleurisy |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Positive | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Influenza | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Measles | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Eczema | | <input type="checkbox"/> Whiplash |

INJURIES/SURGERIES:

Description

Date

Accidents/Falls

Head Injuries

Broken Bones

Dislocations

Surgeries

MEDICINES:

Medication:

Taken For:

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ALLERGIES:

VITAMINS/SUPPLEMENTS:

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FAMILY HISTORY:

	Diabetes	Heart	Kidney	Cancer	Back	Other
Mother – Living <input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<hr/>
Father – Living <input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<hr/>
Brother(s), # of _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<hr/>
Sister(s), # of _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<hr/>
Grandmother(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<hr/>
Grandfather(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<hr/>
Adoption History	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<hr/>