Health History Form

Please Print Date_____

Name_____

Address_____

City_____ State_____ Zip_____

Home Phone_____ Office Phone_____

E-mail Address _____

Age _____ Date of Birth_____ Occupation _____ Sex (M) ___ (F) ___

Weight _____ Referred by _____

Employer _____ Address_____

Married _____ S _____ W_____ D _____ Children _____ Name of Spouse_____

Is any other member of your family being treated in this office? _____

Have you ever had chiropractic care before? _____

For what problem? _____

Were the results satisfactory? Yes _____ No _____ N/A _____

Current problem_____

_____

_____

_____

How do you believe your problem (pain) began?

_____

_____

_____

When did you first notice this problem / pain? _____

Have you lost any work? _____ Day and date you last worked_____

Have you ever had this condition before or a similar condition? _____

When? _____

Health History Form

What positions or activities aggravate your condition? _____

What positions or activities relieve your condition? _____

Have you been treated by a Medical Physician for this ailment? _____

Where? _____

Describe the type of treatment _____

Diagnosis of previous physician _____

Length of time under care _____ Results _____

Family physician's name _____

Will this case be covered by any insurance company? Major Medical ____ Auto _____ Blue Cross/Blue Shield _____ Workers' Compensation ____ Medicare _____ Other _____

Have you ever been in any accidents: auto, fall down stairs, fall from ladder, etc. (even as a child)? _____ When? _____

Are you allergic to anything you are aware of? _____

Are you presently taking any medications (aspirin included)? Yes _____ No _____

If yes, name them _____

_____

Have you ever broken any bones? (fractures) _____ Any dislocations? _____

What operations have you had? _____ Year _____

_____ Year _____

_____ Year _____

Have you had any cosmetic surgery, breast implants, etc.? _____ Year _____

Have you had any surgery to replace hip, knee, etc.? _____ Year _____

Give dates you have had any of the following (if exact date is unknown, give approximate date)

Blood test _____ Urinalysis _____

MRI _____ CT Scan _____ Ultrasound _____

Radiation Treatment _____ X- Ray Examination _____

Other special treatment _____

At what hospital or office were these tests taken? _____

Name of doctor who ordered tests _____

Date of last menstrual period _____

Do you have any reason to believe that you may be pregnant? Yes _____ No _____

Do you take vitamins? Yes _____ No _____ If, yes, please list them _____

_____

Do you exercise regularly? Yes ____ No _____ what, kind of exercise? _____

_____

Please indicate if you use any of the following:

Cigarettes _____ Quantity _____ Coffee _____ Quantity_____

Alcohol _____ Quantity _____ Tea _____ Quantity_____

Hobbies _____

Have you been treated for any health condition by a physician in the past year? _____

If Yes, what condition? _____

Have you lost or gained weight in the past year?_____
Use this space for any additional information you may wish to discuss._____
_____
_____

_____

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Health History Form

Have you had or do you have any of the following symptoms which are or have been significant distress to you? Please indicate with the letter **N** if you have these conditions now (within the past 12 months) or **P** if you ever had this condition in the past.

	N	P		N	P
Headaches	_____	_____	Frequency Loss of balance	_____	_____
Neck Pain	_____	_____	Fainting	_____	_____
Stiff Neck	_____	_____	Loss of Smell	_____	_____
Sleeping Problems	_____	_____	Loss of Taste	_____	_____
Back Pain	_____	_____	Diarrhea	_____	_____
Nervousness	_____	_____	Feet Cold	_____	_____
Tension	_____	_____	Hands Cold	_____	_____
Irritability	_____	_____	Arthritis	_____	_____
Chest Pains	_____	_____	Muscle Spasms	_____	_____
Dizziness	_____	_____	Frequent Colds	_____	_____
Shoulder/Neck/Arm Pain	_____	_____	Stomach Upset	_____	_____
Pins & Needles in Arms	_____	_____	Constipation	_____	_____
Pins & Needles in leg	_____	_____	Cold Sweats	_____	_____
Numbness in Fingers	_____	_____	Fever	_____	_____
Numbness in Toes	_____	_____	Sinus Problems	_____	_____
High Blood pressure	_____	_____	Diabetes	_____	_____
Difficulty Urinating	_____	_____	Hemorrhoids	_____	_____
Allergies	_____	_____	Leg Cramps	_____	_____
Weakness in legs	_____	_____	Gall Bladder	_____	_____
Shortness of Breath	_____	_____	Indigestion	_____	_____
Fatigue	_____	_____	Belching	_____	_____
Depression	_____	_____	Vomiting	_____	_____
Lights Bother Eyes	_____	_____	Shoulder Pain	_____	_____
Loss of Memory	_____	_____	Swelling Joints	_____	_____
Ears Ring	_____	_____	Knee Pain	_____	_____
Face Flushed	_____	_____	Hay fever	_____	_____
Buzzing in Ears	_____	_____	Menstrual Difficulties	_____	_____

I understand and agree that health and accident insurance policies are an agreement between the insurance carrier and myself, and that all services rendered me are charged directly to me, and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

PATIENT SIGNATURE _____

SOCIAL SECURITY NUMBER _____ DATE _____

PATIENT NAME (please print)_____

DATE OF BIRTH _____

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Do you have chest pain?	Yes _____ No _____
Do you have any change in bowel or bladder habits?	Yes _____ No _____
Do you have a sore that does not heal?	Yes _____ No _____
Do you have any unusual bleeding or discharge?	Yes _____ No _____
Do you have thickening in your breast or elsewhere?	Yes _____ No _____
Do you have indigestion or difficulty in swallowing?	Yes _____ No _____
Do you have a change in any wart or mole?	Yes _____ No _____
Do you have a nagging cough or hoarseness?	Yes _____ No _____
Do you have headaches for hours or days?	Yes _____ No _____
Do you have blurred vision?	Yes _____ No _____
Do you have night sweats?	Yes _____ No _____
Do you have pain in neck, jaw or face?	Yes _____ No _____
Do you have a drooping eyelid or any change in your pupils?	Yes _____ No _____
Do you have vertigo (dizziness)?	Yes _____ No _____
Do you have double vision?	Yes _____ No _____
Do you have any visual disturbances?	Yes _____ No _____
Do you have any nausea or vomiting?	Yes _____ No _____
Do you have any slurred speech?	Yes _____ No _____
Do you have any ringing in your ears?	Yes _____ No _____
Do you pass out easily (faint)?	Yes _____ No _____
Do you take birth control pills?	Yes _____ No _____
Do you have a history of stroke in your family?	Yes _____ No _____

List allergies or adverse reactions to medications _____

_____

Have you ever had cancer?	Yes ____ No _____
Does your pain ever wake you from a sound sleep?	Yes ____ No _____
Are you losing weight now without trying?	Yes ____ No _____
Are you coughing up blood or noticing it in your stools or urine?	Yes ____ No _____
Have you had any loss of bladder or bowel control?	Yes ____ No _____
Have you lost consciousness recently?	Yes_____ No_____

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Are you seeing any other doctor now for any reason? Yes ____ No _____

Note: _____

Are you taking any over-the-counter drugs? Yes ____ No _____

Please indicate type (aspirin, etc.)_____

SOCIAL HISTORY

Smoker _____ Yes or _____ No, If Yes, How many packs _____
Alcohol _____ Yes or _____ No, If Yes, How much_____

FAMILY HISTORY
Did your mother or father have any of the following:
Put an **M** for mother, **F** for father, and **B** for both

( ) High Blood Pressure
( ) Heart Attack
( ) Emphysema
( ) Seizures-Convulsions
( ) HIV Positive
( ) Asthma
( ) Diabetes
( ) Kidney Disease
( ) Pacemaker
( ) Ulcer or Stomach Problems
( ) Stroke
( ) Arthritis-Rheumatism
( ) Mental Illness
( ) Thyroid Disease
( ) Circulation Problems
( ) Cancer
( ) Osteoporosis

Comments:_____
_____
_____
_____
_____