Health History Form

Name____ **Today's Date**_______________________

Reason for Your Visit

Nature of injury/complaint: ☐ Automobile ☐ Work ☐ Other____________________________________

What is your major complain?____

____

Other complaints?____

____

Date symptoms appeared: __________________

Have you ever had the same condition? ☐ Yes ☐ No If Yes, when______________________________

How long has it been since you felt good? ☐ Days ☐ Weeks ☐ Months ☐ Years

Do your symptoms interfere with daily life? ☐ Yes ☐ No

Does pain wake you up at night? ☐ Yes ☐ No

Are your symptoms worse during certain times of the day? ☐ Yes ☐ No

Do changes in the weather affect your symptoms? ☐ Yes ☐ No

What aggravates your symptoms? ____

What relieves your symptoms?____

What percentage of the time does this condition bother you? ☐ 0% ☐ 25% ☐ 50% ☐ 75% ☐ 100%

How would you rate the level of discomfort on a scale of 0-10? (0=No pain 10=Extreme Pain)_________

Have you ever been under chiropractic care? ☐ Yes ☐ No

Have you ever had a massage? ☐ Yes ☐ No Have you ever had acupuncture? ☐ Yes ☐ No

Are you interested in nutritional consultation? ☐ Yes ☐ No

Others who have treated you for this condition: ____

Females: Are you taking birth control? ☐ Yes ☐ No If yes, explain:______________________

____

Are you or could you be pregnant? ☐ Yes ☐ No If yes, how long?____________

Are you currently nursing? ☐ Yes ☐ No If yes, how long?____________

Date of first day of last menstrual period:______________________

Please initial the following statement. To the best of my knowledge I am NOT pregnant.

I give my permission for x-rays to be taken as needed. __________

Have you ever had any of the following diseases/medical condition(s)?

Y N Alcohol/Drug Use
Y N Allergies
Y N Anemia
Y N Arteriosclerosis
Y N Arthritis
Y N Artificial Bones/Joints
Y N Artificial Valves/Mitral Valve Prolapse
Y N Asthma/Bronchitis
Y N Back Pain
Y N Bruise Easily
Y N Cancer
Y N Chemotherapy
Y N Chest Pain/Conditions
Y N Chicken Pox/ Shingles
Y N Cold Extremities
Y N Colitis
Y N Congenital Heart Disease
Y N Congestive Heart Failure
Y N Constipation
Y N Cramps
Y N Diabetes
Y N Difficulty Breathing
Y N Digestion Problems
Y N Dizziness/ Loss of Balance
Y N Ears Ringing
Y N Emphysema/COPD
Y N Epilepsy/Seizures
Y N Excessive/Irregular Menstruation
Y N Glaucoma/Eye Pain/Difficulties
Y N Fainting
Y N Fatigue
Y N Frequent Urination/Kidney Problems
Y N Heart Attack
Y N Heart Murmur/Irregular Heartbeat
Y N Heart Surgery
Y N Hemorrhoids
Y N Hepatitis
Y N High/Low Blood Pressure
Y N HIV+/AIDS
Y N Hot Flashes/Menopause
Y N Loss of Memory
Y N Loss of Smell/Taste
Y N Multiple Sclerosis (MS)
Y N Near Death Experience
Y N Nosebleeds
Y N Pacemaker
Y N Prostate Trouble
Y N Sciatica
Y N Severe/Frequent Headaches
Y N Sinus Problems
Y N Sleep Problems or Insomnia
Y N Spinal Curvatures/Scoliosis
Y N Stroke
Y N Swelling of the Ankles
Y N Swollen Joints
Y N Thyroid Condition
Y N Tuberculosis
Y N Ulcers
Y N Venereal Disease
Y N Other: ______________________

Please list any other serious medical condition(s) you have or ever had:____

____

Please list any medications you are currently taking:____

____

Please list any vitamins or supplements you are currently taking:____

____

Please list anything you may be allergic to:____

____

Have you ever been hospitalized? ☐ Yes ☐ No If yes, explain:____

____

List all previous surgeries/treatments with dates:____

____

List any and all accidents with dates:____

____

Have you ever been given a psychiatric diagnosis? ☐ Yes ☐ No If yes, explain:_________________________________

____

Have had had any x-rays, MRI's or other advanced imaging? ☐ Yes ☐ No If yes, explain:__________________________

____

Do you exercise? ☐ Yes ☐ No If yes: How much?_______________ How long?______________________________

Do you smoke? ☐ Yes ☐ No If yes: How much?_________________ How long?_____________________________

Do you wear: ☐ Heal lifts ☐ Sole lifts ☐ Inner soles ☐ Arch supports ☐ Orthotics

How old is your mattress?_________________ Is it comfortable? ☐ Yes ☐ No