

Health History

Patient Name: _____

Date: ____ / ____ / ____

Describe Reason(s) for appointment today, beginning with highest priority: If No health concerns write "Wellness Checkup"

1. _____ 2. _____
3. _____ 4. _____

Explanation of how problem(s) occurred:

1. _____ 2. _____
3. _____ 4. _____

Problem started when: 1. ____ / ____ / ____ 2. ____ / ____ / ____ 3. ____ / ____ / ____ 4. ____ / ____ / ____

Your Chiropractic Care will be filed as: **Auto Insurance** **Worker's Compensation** **Personal Insurance** **Cash**

Frequency/Duration of Problem: Constant / Daily / Weekly / Monthly For How Long: _____

Prior Occurrences: Yes / No How many times: _____ **Worse in:** A.M. / P.M. / Both

What makes it better: _____ What makes it worse: _____

What were/are you doing for the Problem: _____

Does Problem Interfere with work: Yes / No **Does Problem Affect Sleep:** Yes / No **Routine:** Yes / No

Is Problem Getting Progressively Worse: Yes / No **History of Trauma to Area:** Yes / No When: _____

Other Health Care Providers seen for this problem: _____

Type of Treatment: _____ Results: _____

Sleeping habits: ___ On back, ___ On side, ___ Side w/ arm extended, ___ On stomach

Hours of sleep a day: _____ On a scale 1-10 what level stress do you experience daily? _____

Sleep Problems: Explain _____

Exercise Routine: Explain _____

How many Meals a Day: _____ How Many Servings a day: Meat: _____ Vegetables: _____ Fruit: _____

Habits: Tobacco # a day: _____ (Cigarettes Chewing tobacco Cigar Pipe) Alcohol # a week: _____

Coffee # a day: _____ Soft Drinks # a day: _____ Tea # a day: _____ Crave Salty Foods: Yes / No

Crave Ice Cream: Yes / No Diet Foods: Yes / No Fast Food # a week: _____

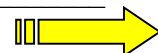
Glasses of water a day? _____ Frequent Activities/Hobbies: _____

Female: Last date of Menstrual Cycle _____ **Pregnant:** NO / YES Due Date: _____

Past history of family illnesses or diseases:

Relationship: _____	Illness: _____	Age: _____	Living / Deceased
Relationship: _____	Illness: _____	Age: _____	Living / Deceased
Relationship: _____	Illness: _____	Age: _____	Living / Deceased
Relationship: _____	Illness: _____	Age: _____	Living / Deceased
Relationship: _____	Illness: _____	Age: _____	Living / Deceased

Other/Comments: _____

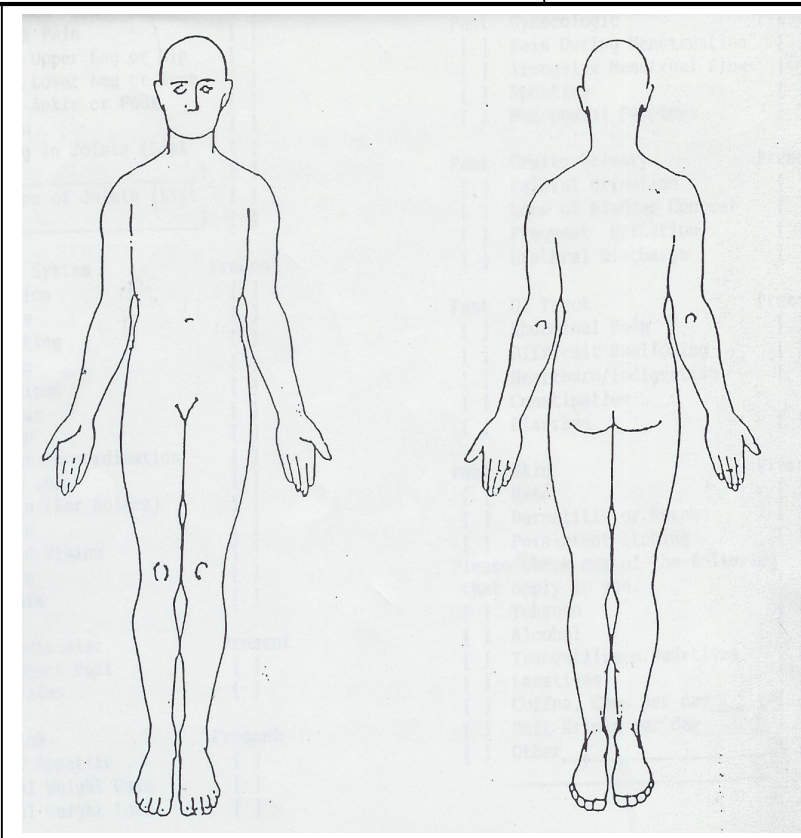


Listed below are common symptoms. If you have ever had a listed symptom in the **past** or **present** please check that symptom in the appropriate column.

Past	Musculoskeletal	Present
<input type="checkbox"/>	Neck Pain	<input type="checkbox"/>
<input type="checkbox"/>	Shoulder Pain	<input type="checkbox"/>
<input type="checkbox"/>	Pain in Upper Arm or Elbow	<input type="checkbox"/>
<input type="checkbox"/>	Hand Pain	<input type="checkbox"/>
<input type="checkbox"/>	Upper Back Pain	<input type="checkbox"/>
<input type="checkbox"/>	Numbness	<input type="checkbox"/>
<input type="checkbox"/>	Low Back Pain	<input type="checkbox"/>
<input type="checkbox"/>	Pain in Upper Leg or Hip	<input type="checkbox"/>
<input type="checkbox"/>	Pain in Lower Leg or Knee	<input type="checkbox"/>
<input type="checkbox"/>	Pain in Ankle or Foot	<input type="checkbox"/>
<input type="checkbox"/>	Jaw Pain	<input type="checkbox"/>
<input type="checkbox"/>	Swelling in Joints	<input type="checkbox"/>
	List Joints _____	
<input type="checkbox"/>	Stiffness of Joints	<input type="checkbox"/>
	List Joints _____	
Past	Nervous System	Present
<input type="checkbox"/>	Depression	<input type="checkbox"/>
<input type="checkbox"/>	Insomnia	<input type="checkbox"/>
<input type="checkbox"/>	Bed Wetting	<input type="checkbox"/>
<input type="checkbox"/>	Convulsions	<input type="checkbox"/>
<input type="checkbox"/>	Dizziness/Fainting	<input type="checkbox"/>
<input type="checkbox"/>	Headache	<input type="checkbox"/>
<input type="checkbox"/>	Muscular Incoordination	<input type="checkbox"/>
<input type="checkbox"/>	Hearing Loss	<input type="checkbox"/>
<input type="checkbox"/>	Tinnitus (Ear Noises)	<input type="checkbox"/>
<input type="checkbox"/>	Ear Pain	<input type="checkbox"/>
<input type="checkbox"/>	Impaired Vision	<input type="checkbox"/>
<input type="checkbox"/>	Eye Pain	<input type="checkbox"/>
<input type="checkbox"/>	Paralysis	<input type="checkbox"/>

Past	Cardiovascular	Present
<input type="checkbox"/>	Rapid Heart Beat	<input type="checkbox"/>
<input type="checkbox"/>	Slow Heart Beat	<input type="checkbox"/>
<input type="checkbox"/>	Swelling Ankles	<input type="checkbox"/>
<input type="checkbox"/>	Poor Circulation	<input type="checkbox"/>
<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>
<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>
<input type="checkbox"/>	Chest Pains	<input type="checkbox"/>
Past	Endocrine	Present
<input type="checkbox"/>	Loss of Appetite	<input type="checkbox"/>
<input type="checkbox"/>	Abnormal Weight Gain	<input type="checkbox"/>
<input type="checkbox"/>	Abnormal Weight Loss	<input type="checkbox"/>
Past	Respiratory	Present
<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>
<input type="checkbox"/>	Chronic Cough	<input type="checkbox"/>
<input type="checkbox"/>	Sinus Infection	<input type="checkbox"/>
Past	Gynecologic	Present
<input type="checkbox"/>	Lumps in Breast	<input type="checkbox"/>
<input type="checkbox"/>	Cramps or back aches	<input type="checkbox"/>
<input type="checkbox"/>	Irregular Menstrual Flow	<input type="checkbox"/>
<input type="checkbox"/>	Vaginal Discharge	<input type="checkbox"/>
<input type="checkbox"/>	Spotting	<input type="checkbox"/>
<input type="checkbox"/>	Menopausal Symptoms	<input type="checkbox"/>
Past	Genito-Urinary	Present
<input type="checkbox"/>	Painful Urination	<input type="checkbox"/>
<input type="checkbox"/>	Loss of Bladder Control	<input type="checkbox"/>
<input type="checkbox"/>	Frequent Urination	<input type="checkbox"/>
<input type="checkbox"/>	Urethral Discharge	<input type="checkbox"/>
<input type="checkbox"/>	Blood In Urine	<input type="checkbox"/>

Past	GI Tract	Present
<input type="checkbox"/>	Abdominal Pain	<input type="checkbox"/>
<input type="checkbox"/>	Difficult Swallowing	<input type="checkbox"/>
<input type="checkbox"/>	Heartburn/ Indigestion	<input type="checkbox"/>
<input type="checkbox"/>	Constipation	<input type="checkbox"/>
<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>
<input type="checkbox"/>	Liver Trouble	<input type="checkbox"/>
<input type="checkbox"/>	Laxatives	<input type="checkbox"/>
Past	Skin	Present
<input type="checkbox"/>	Rash	<input type="checkbox"/>
<input type="checkbox"/>	Dermatitis or Eczema	<input type="checkbox"/>
<input type="checkbox"/>	Persistent Itching	<input type="checkbox"/>
Past	Condition	Present
<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>
<input type="checkbox"/>	Emphysema	<input type="checkbox"/>
<input type="checkbox"/>	Rheumatic Heart Disease	<input type="checkbox"/>
<input type="checkbox"/>	Arthritis	<input type="checkbox"/>
<input type="checkbox"/>	Asthma	<input type="checkbox"/>
<input type="checkbox"/>	Drug or Alcohol Dependency	<input type="checkbox"/>
<input type="checkbox"/>	Angina	<input type="checkbox"/>
<input type="checkbox"/>	Diabetes	<input type="checkbox"/>
<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>
<input type="checkbox"/>	Ulcer	<input type="checkbox"/>
<input type="checkbox"/>	Stroke	<input type="checkbox"/>
<input type="checkbox"/>	Kidney Stones	<input type="checkbox"/>
<input type="checkbox"/>	Bladder Infection	<input type="checkbox"/>
<input type="checkbox"/>	Kidney Infection	<input type="checkbox"/>
<input type="checkbox"/>	Gall Bladder	<input type="checkbox"/>
<input type="checkbox"/>	Cancer	<input type="checkbox"/>
<input type="checkbox"/>	Prostate Troubles	<input type="checkbox"/>
<input type="checkbox"/>	HIV Positive/AIDS	<input type="checkbox"/>
<input type="checkbox"/>	Other _____	<input type="checkbox"/>



PAIN DRAWING

If you are experiencing pain, accurately mark the location and type of pain on the body to the left. Use the appropriate letter(s), to mark all affected areas.

Stabbing (S) Ache (A) Numbness (N)

Tingling (T) Burning (B)

Please mark on the line the **pain level (0-10)** that most accurately represents your pain:

Right Now _____
 Average Pain _____
 At Best _____
 At Worst _____

(Pain Scale)

(NO PAIN) **0 1 2 3 4 5 6 7 8 9 10** (UNBEARABLE PAIN)