## Chiropractic Health History:

Name_____ Sex M F Date_____

Date of Birth____/____/_____

Have you ever received chiropractic care? Y / N If yes, when?_____

Primary reason for seeking chiropractic care now?_____

Secondary reason_____

Other reasons_____

**Past Health History: Please be as complete as possible**

Previous illnesses you've had in your life_____

Previous injuries or trauma_____

Previous broken bones and when?_____

Allergies?_____

List any medications, vitamins, supplements, homeopathic remedies and herbs? And what condition it is for?_____

_____

_____

Surgeries and dates:_____

Pregnancies, Date of Delivery and Outcomes_____

_____

Date of the beginning of your last menstrual period?____/____/_____Any menstrual problems?_____

**Family Health History:**

Has anyone in your family had any of the following conditions? Blindness, cataracts, glaucoma, arthritis, cancer, diabetes, heart disease, high blood pressure, elevated cholesterol, thyroid disease, migraines, allergies, phychiatric disorders?

Who/Age?_____

Deaths in the immediate family, Ages, Cause of Death?_____

**Social/Occupational History:** These are important in prevention and often times, finding the cause and the cure.

Education_____

Job description_____

Recreational activities/Exercise Habits_____

Eating Habits_____

**Please mark each item below for each sign or symptom you presently have (X) or previously had (+)- also include date:**

**GENERAL SYMPTOMS**
__ Dizziness
__ Fainting
__ Fever
__ Nervousness
__ Numbness
__ Wheezing
__ Insomnia

**NEUROLOGICAL**
__ Headaches
__ Migraines
__ Seizures
__ Convulsions

**MUSCLES & JOINTS**
__ Low Back Problems
__ Hip Pain
__ Pain between Shoulders
__ Neck Problems
__ Arm Problems
__ Leg Problems
__ Swollen Joints
__ Painful Joints
__ Stiff Joints
__ Sore Muscles
__ Weak Muscles
__ Walking Problems
__ Sprains/Strains
__ Broken Bones
__ Rheumatoid Arthritis

**CARDIO-VASCULAR**
__ High Blood Pressure
__ Heart Attack
__ Pain over Heart
__ Poor Circulation
__ Heart Trouble
__ Rapid Heart
__ Slow Heart
__ Strokes
__ Swelling Ankles
__ Varicose Veins

**EAR/NOSE/THROAT**
__ Earache
__ Ear Noises
__ Enlarged Thyroid
__ Frequent Colds
__ Hay Fever
__ Nasal Blockage
__ Nose Bleeds
__ Pain Behind Eyes
__ Poor Vision
__ Sinusitis
__ Sore Throats
__ Tonsillitis

**GASTRO-INTESTINAL**
__ Belching/Gas
__ Colon Problems
__ Constipation
__ Diarrhea
__ Excessive Hunger
__ Excessive Thirst
__ Gall Bladder
__ Hemorrhoids
__ Liver
__ Nausea
__ Abdominal Pain
__ Ulcer
__ Poor Appetite
__ Poor Digestion
__ Vomiting
__ Vomiting Blood
__ Black Stool
__ Bloody Stool
__ Weight Loss/Gain

**PHYCHIATRIC**
__ Depression
__ Anxiety
__ Mood swings
__ Hallucinations
__Attention Issues
__ Panic Attacks

**RESPIRATORY**
__ Asthma
__ Emphysema
__ Chronic Cough
__ Difficulty Breathing
__ Spitting Blood
__ Spitting Phlegm

**GENITO-URINARY**
__ Blood in Urine
__ Frequent Urination
__ Kidney Infection
__ Painful Urination
__ Prostate Problems
__ Loss of Bladder Control
__ Genital Concerns

**SKIN OR ALLERGIES**
__ Boils
__ Bruising Easily
__ Dryness
__
Eczema/Rash/Dermatitis
__ Hives
__ Itching
__ Sensitive Skin
__ Allergy

**EYES**
__ Glasses/Contacts
__ Eye Concerns

**FOR WOMEN ONLY**
__ Birth Control
__ Hormone Replacement
__ Cramps/Backaches
__ Excessive Flow
__ Hot Flashes
__ Irregular Cycle
__ Miscarriage
__ Painful Periods
__ Vaginal Discharge
__ Breast Pain
Pregnant at this Time Y/N

Are there any other health concerns you would like to address? Y / N; if YES, what?_____
On a scale of 1-10, how committed are you to resolving this complaint?_____

I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my health. I agree to allow this office to examine me for further evaluation and provide me with chiropractic care.

Patient
Signature_____Date_____