

Personal Health History

Patient's Name _____ DOB _____ Date _____

All information will be kept strictly confidential. Your responses will help determine if chiropractic treatment will benefit you. Unless we sincerely feel that your condition will respond satisfactorily, we will not recommend treatment. Please check the degree of all conditions you currently have or have had. To be responsible for your case, we need your complete health history.

O = Occasional F = Frequent C = Constant

<p>O F C Muscle / Joint</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Arthritis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bursitis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Foot trouble <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hernia <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Low back pain <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Lumbago <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Neck pain, stiffness <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Pain between shoulders</p> <p>General</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Allergy <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Chills <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Convulsions <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Dizziness <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Fainting <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Fatigue <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Fever <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Headache <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Loss of sleep <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Loss of weight <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Nervousness, depression <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Neuralgia <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Numbness <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sweats <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Tremors</p> <p>Cardiovascular</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hardening of arteries <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> High blood pressure <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Low blood pressure <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Pain over heart <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Poor circulation <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Rapid heartbeat <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Slow heartbeat <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Swelling of ankles</p> <p>Genitourinary</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bed-wetting <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Blood in urine <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Frequent urination <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Lack of kidney control <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Kidney infection <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Painful urination <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Prostate trouble <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Pus in urine</p>	<p>O F C O F C Eye, Ear, Nose and Throat</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Asthma <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Colds <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Crossed eyes <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Deafness <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Dental decay <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Earache <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Ear discharge <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Ear noise <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Enlarged glands <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Enlarged thyroid <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Eye pain <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Failing vision <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Far sightedness <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Gum trouble <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hay fever <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hoarseness <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Nasal obstruction <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Near sightedness <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Nose bleeds <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sinus infection <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sore throat <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Tonsillitis</p> <p>Gastrointestinal</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Belching or gas <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Colitis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Colon trouble <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Constipation <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Diarrhea <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Difficult digestion <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bloated abdomen <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Excessive hunger <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Gallbladder trouble <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Intestinal worms <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Jaundice <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Liver trouble <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Nausea <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Pain over stomach <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Poor appetite <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Vomiting <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Vomiting of blood</p>	<p>O F C O F C Skin</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Boils <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bruise easily <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Dryness <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hives or allergy <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Itching <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Skin eruptions (rash) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Varicose veins</p> <p>Pain or numbness in</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Shoulders <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Arms <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Elbows <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hand <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hips <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Legs <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Knees <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Feet <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Painful tailbone <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Poor posture <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sciatica <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Spinal curvature <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Swollen joints</p> <p>Respiratory</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Chest pain <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Chronic cough <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Difficult breathing <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Spitting up blood <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Spitting up phlegm <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Wheezing</p> <p>Women only</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Congested breasts <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Cramps or backache <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Excess menstrual flow <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hot flashes <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Irregular cycle <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Lumps in breast <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Menopause <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Painful menstruation <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Vaginal discharge</p> <p>Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many months? _____ How many children do you have? _____</p>	<p><i>Check any of the following conditions</i> <i>Check any of the following conditions you currently have or have had:</i></p> <p><input type="checkbox"/> Alcoholism <input type="checkbox"/> Anemia <input type="checkbox"/> Appendicitis <input type="checkbox"/> Arteriosclerosis <input type="checkbox"/> Cancer <input type="checkbox"/> Chicken pox <input type="checkbox"/> Cholera <input type="checkbox"/> Cold sores <input type="checkbox"/> Diabetes <input type="checkbox"/> Diphtheria <input type="checkbox"/> Eczema <input type="checkbox"/> Edema <input type="checkbox"/> Emphysema <input type="checkbox"/> Epilepsy <input type="checkbox"/> Fever blisters <input type="checkbox"/> Goiter <input type="checkbox"/> Gout <input type="checkbox"/> Heart disease <input type="checkbox"/> Herpes <input type="checkbox"/> Influenza <input type="checkbox"/> Lumbago <input type="checkbox"/> Malaria <input type="checkbox"/> Measles <input type="checkbox"/> Miscarriage <input type="checkbox"/> Multiple sclerosis <input type="checkbox"/> Mumps <input type="checkbox"/> Pacemaker <input type="checkbox"/> Pleurisy <input type="checkbox"/> Pneumonia <input type="checkbox"/> Polio <input type="checkbox"/> Rheumatic fever <input type="checkbox"/> Scarlet fever <input type="checkbox"/> Stroke <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Typhoid fever <input type="checkbox"/> Ulcers <input type="checkbox"/> Venereal disease <input type="checkbox"/> Whooping cough</p>
---	--	--	--

Describe chiropractic problem: _____

over -->

How long have you had this condition?	Is it getting worse? <input type="checkbox"/> Yes <input type="checkbox"/> No
Does it bother your (check appropriate box): <input type="checkbox"/> Work <input type="checkbox"/> Sleep <input type="checkbox"/> Other (please specify)	

Personal Health History

What seemed to be the initial cause?
Have you seen a chiropractor before? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how long ago? _____ For what reason?
Are you under the care of a physician? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, for what reason?

Have you been hospitalized in the last 5 years? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, for major surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No for serious injury? <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you had any mental or emotional disorders? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when?
Indicate the drugs do you now take? <input type="checkbox"/> Birth control pills <input type="checkbox"/> Tranquilizers <input type="checkbox"/> Pain Killers <input type="checkbox"/> Other (specify)
Do you wear: <input type="checkbox"/> heel lifts? <input type="checkbox"/> sole lifts? <input type="checkbox"/> inner soles? <input type="checkbox"/> area supports? <input type="checkbox"/> negative heels? <input type="checkbox"/> platform shoes?
What is the age of your mattress? _____ Is it <input type="checkbox"/> comfortable? <input type="checkbox"/> uncomfortable? Do you use a bedboard? <input type="checkbox"/> Yes <input type="checkbox"/> No
How is most of your day spent? <input type="checkbox"/> standing <input type="checkbox"/> sitting <input type="checkbox"/> walking <input type="checkbox"/> other (specify)

Have you ever:

	Yes	No
- had a broken bone?	<input type="checkbox"/>	<input type="checkbox"/>
- been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>
- had strains or sprains?	<input type="checkbox"/>	<input type="checkbox"/>
- used a cane, crutch or other support?	<input type="checkbox"/>	<input type="checkbox"/>
- been struck unconscious?	<input type="checkbox"/>	<input type="checkbox"/>
- been hospitalized for other than surgery?	<input type="checkbox"/>	<input type="checkbox"/>

Do you:

- take minerals, herbs or vitamins?	<input type="checkbox"/>	<input type="checkbox"/>
- think you need minerals, herbs or vitamins?	<input type="checkbox"/>	<input type="checkbox"/>
- have any drug allergy?	<input type="checkbox"/>	<input type="checkbox"/>

If answered yes, to any of the above questions briefly explain: _____

HABITS	None	Light	Mod	Heavy
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Soft Drinks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Salty Foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sugar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Sweeteners	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

When did you last have:

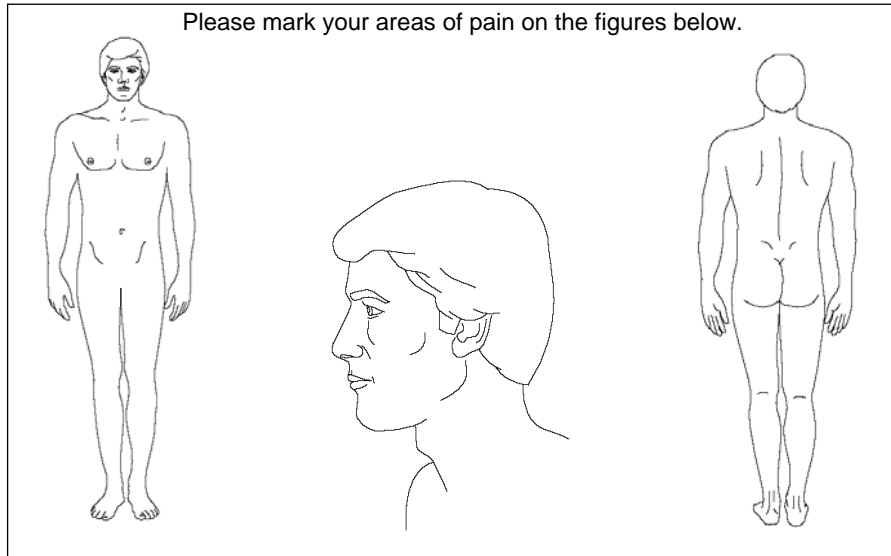
	Never	0-6 mos.	6 -18 mos.	longer
- spinal x-ray?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- spinal examination?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- physical examination?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please list any other health conditions you have been treated for, or surgery you have had in the last ten years.

FAMILY HEALTH HISTORY: Information about your immediate family members, brothers, sisters, parents, and grandparents will give us a better understanding of your total health picture.

RELATIONSHIP	PRESENT AND PAST HEALTH PROBLEMS

Personal Health History



Patient signature: _____