HEALTH HISTORY FORM

CASE NO

FOR OFFICE USE ONLY

DATE

PLEASE COMPLETE FORM.

NAME

ADDRESS

CITY STATE ZIP

HOME NUMBER OFFICE NUMBER

EMAIL ADDRESS

AGE DATE OF BIRTH SEX: ☐ MALE ☐ FEMALE WEIGHT

OCCUPATION REFERRED BY

STATUS: ☐ MARRIED ☐ SINGLE ☐ WIDOWED ☐ DIVORCED SPOUSE

CHILDREN

EMPLOYER ADDRESS

ARE ANY OTHER MEMBERS OF YOUR FAMILY BEING TREATED IN THIS OFFICE? ☐ YES ☐ NO

HAVE YOU EVER HAD CHIROPRACTIC CARE BEFORE? ☐ YES ☐ NO

FOR WHAT PROBLEM?

WERE THE RESULTS SATISFACTORY? ☐ YES ☐ NO ☐ N/A

MAJOR COMPLAINTS AND SYMPTONS *(BE SPECIFIC. ASK FOR HELP IF YOU NEED ASSISTANCE IN FILLING OUT THIS SECTION.)*

HOW DO YOU BELIEVE YOUR PROBLEM/PAIN BEGAN?

WHEN DID YOU FIRST NOTICE THIS PROBLEM/PAIN? **HAVE YOU LOST ANY WORK?** ☐ YES ☐ NO **DATE YOU LAST WORKED**

HAVE YOU EVER HAD THIS OR A SIMILAR CONDITION BEFORE? ☐ YES ☐ NO **WHEN?**

WHAT POSITIONS OR ACTIVITIES AGGRAVATE YOUR CONDITION?

WHAT POSITIONS OR ACTIVITIES RELIEVE YOUR CONDITION?

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HAVE YOU BEEN TREATED BY A MEDICAL PHYSICIAN FOR THIS AILMENT?
☐ YES ☐ NO

WHERE?

DESCRIBE THE TYPE OF TREATMENT

DIAGNOSIS OF PREVIOUS PHYSICIAN

LENGTH OF TIME UNDER CARE

RESULTS

FAMILY PHYSICIAN'S NAME

WOULD YOU LIKE A REPORT SENT TO YOUR FAMILY PHYSICIAN?
☐ YES ☐ NO

WILL THIS CASE BE COVERED BY ANY INSURANCE COMPANY?
☐ YES ☐ NO
☐ MAJOR MEDICAL ☐ AUTO
☐ BLUE CROSS/BLUE SHIELD ☐ WORKMANS' COMPENSATION
☐ MEDICARE ☐ OTHER

HAVE YOU EVER BEEN IN ANY ACCIDENTS (AUTO, FALLEN DOWN STAIRS, FALLEN FROM LADDER, ETC.) *(INCLUDE CHILDHOOD INJURIES)*?
☐ YES ☐ NO
WHEN?

DO YOU HAVE ANY ALLERGIES? ☐ YES ☐ NO
IF YES, PLEASE LIST

ARE YOU CURRENTLY TAKING ANY MEDICATION? *(INCLUDE ASPIRIN)*
☐ YES ☐ NO
IF YES, PLEASE LIST

HAVE YOU EVER BROKEN ANY BONES (FRACTURES)? ☐ YES ☐ NO
ANY DISLOCATIONS? ☐ YES ☐ NO
IF YES, PLEASE LIST

PLEASE LIST ANY SURGERIES

SURGERY	YEAR
SURGERY	YEAR
SURGERY	YEAR

HAVE YOU HAD ANY COSMETIC SURGERY (BREAST IMPLANTS, ETC.)?
☐ YES ☐ NO YEAR

HAVE YOU HAD ANY REPLACEMENT SURGERY (HIP, KNEE, ETC.)?
☐ YES ☐ NO YEAR

PROVIDE DATES YOU HAVE HAD ANY OF THE FOLLOWING
(IF EXACT DATE IS UNKNOWN, GIVE APPROXIMATE DATE)

☐ BLOOD TEST	DATE
☐ URINALYSIS	DATE
☐ MRI	DATE
☐ CT SCAN	DATE
☐ ULTRASOUND	DATE
☐ RADIATION TREATMENT	DATE
☐ X-RAY EXAMINATION	DATE
☐ OTHER SPECIAL TREATMENT	DATE

WHAT HOSPITAL/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 HAVE ANY HEALTH PROBLEMS NOT LISTED ABOVE?
☐ YES ☐ NO
IF YES, PLEASE LIST

DO YOU FAINT EASILY? ☐ YES ☐ NO
DO YOU TAKE VITAMINS? ☐ YES ☐ NO
IF YES, PLEASE LIST

DO YOU EXERCISE REGULARLY? ☐ YES ☐ NO
IF YES, PLEASE LIST

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HABITS (PLEASE CHECK ALL THAT APPLY)

☐ CIGARETTES QUANTITY ☐ COFFEE QUANTITY

☐ ALCOHOL QUANTITY ☐ TEA QUANTITY

HOBBIES

HAVE YOU LOST OR GAINED WEIGHT IN THE PAST YEAR?

☐ YES ☐ NO

ADDITIONAL INFORMATION YOU MAY WISH TO DISCUSS

HAVE YOU BEEN TREATED FOR ANY HEALTH CONDITION BY A PHYSICIAN IN THE PAST YEAR?

☐ YES ☐ NO

IF YES, WHAT CONDITION

HAVE YOU HAD OR DO YOU NOW HAVE ANY OF THE FOLLOWING SYMPTOMS WHICH ARE OR HAVE BEEN OF 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 THESE CONDTIONS IN THE PAST (PRIOR TO THE PAST 12 MONTHS).

HEADACHES	IRRITABILITY	NUMBNESS IN TOES	FATIGUE
LOSS OF BALANCE	ARTHRITIS	SINUS PROBLEMS	BELCHING
NECK PAIN	CHEST PAINS	HIGH BLOOD PRESSURE	DEPRESSION
FAINTING	MUSCLE SPASMS	DIABETES	VOMITING
STIFF NECK	DIZZINESS	DIFFICULTY URINATING	LIGHT SENSITIVE EYES
LOSS OF SMELL	FREQUENT COLDS	HEMORRHOIDS	SHOULDER PAIN
PROBLEMS SLEEPING	SHOULDER/NECK/ARM PAIN	ALLERGIES	LOSS OF MEMORY
LOSS OF TASTE	UPSET STOMACH	LEG CRAMPS	SWELLING JOINTS
BACK PAIN	PINS & NEEDLES IN ARMS	WEAKNESS IN ARMS	EARS RING
DIARRHEA	PINS & NEEDLES IN LEGS	WEAKNESS IN LEGS	KNEE PAIN
NERVOUSNESS	CONSTIPATION	COLITIS	FACE FLUSHED
FEET COLD	COLD SWEATS	GALL BLADDER	HAYFEVER
TENSION	NUMBNESS IN FINGERS	SHORTNESS OF BREATH	BUZZING IN EARS
HANDS COLD	FEVER	INDIGESTION	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, AND FEES FOR PROFESSIONAL SERVICES RENDERED ME WILL BE IMMEDIATELY DUE AND PAYABLE.

SIGNATURE

DATE

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DO YOU HAVE CHEST PAIN? ☐ YES ☐ NO

DO YOU HAVE 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 ANY THICKENING IN YOUR BREASTS 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 OTHER 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

WHAT PRESCRIPTION MEDICATION ARE YOU TAKING, IF ANY?

HIGH BLOOD PRESSURE MEDICATION

BLOOD THINNERS

OTHER

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 OR HAD DOUBLE VISION RECENTLY? ☐ YES ☐ NO

ARE YOU SEEING ANY OTHER DOCTOR NOW FOR ANY REASON? ☐ YES ☐ NO

ARE YOU TAKING ANY MEDICATIONS OR OVER-THE COUNTER DRUGS? ☐ YES ☐ NO

IF YES, PLEASE LIST

WHAT WAS THE DATE OF ONSET OF YOUR LAST MENSES?

SOCIAL HISTORY

DO YOU SMOKE? ☐ YES ☐ NO

IF YES, HOW MANY PACKS AND FREQUENCY

DO YOU DRINK ALCOHOL? ☐ YES ☐ NO

IF YES, WHAT DO YOU DRINK? HOW MUCH? AND HOW OFTEN?

FAMILY HISTORY

HAS YOUR MOTHER OR FATHER HAD ANY OF THE FOLLOWING:
PUT AN M = MOTHER, F = FATHER, AND B = BOTH.

HIGH BLOOD PRESSURE	THYROID DISEASE
ULCER/STOMACH PROBLEMS	ASTHMA
HEART ATTACK	CIRCULATION PROBLEMS
STROKE	DIABETES
EMPHYSEMA	CANCER
ARTHRITIS/RHEUMATISM	KIDNEY DISEASE
SEIZURES/CONVULSIONS	OSTEOPOROSIS
MENTAL ILLNESS	PACEMAKER
HIV POSITIVE	

ADDITIONAL COMMENTS

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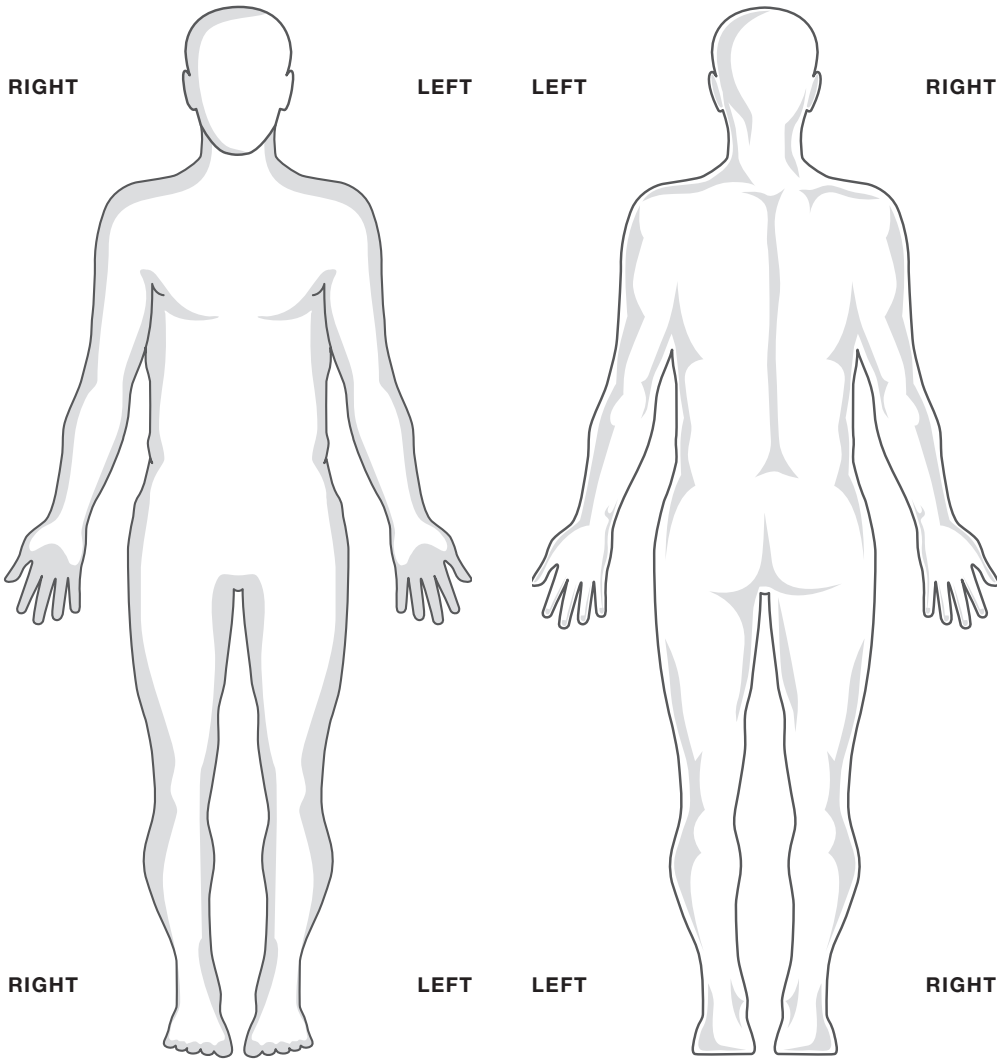
TO INSURE THAT WE HAVE ALL OF YOUR INFORMATION, THIS LAST PAGE SHOWING AREAS OF PAIN MUST BE COMPLETED PRIOR TO YOUR FIRST VISIT. PRINT A COMPLETE COPY OF THIS FORM FOR YOUR RECORDS.

MARK THE AREAS (ON THE BODY DIAGRAM BELOW WHERE YOU FEEL THE DESCRIBED SENSATIONS: USE THE APPROPRIATE SYMBOLS FOR NUMBNESS, PINS AND NEEDLES, BURNING, ACHING, AND STABBING PAIN. MARK AREAS ON DIAGRAM FROM WHERE PAIN RADIATES. INCLUDE ALL AFFECTED AREAS.

NUMBNESS	PINS & NEEDLES	BURNING	ACHING	STABBING
----------	00000000000	xxxxxxxxxxxxx	**********	//////////
----------	00000000000	xxxxxxxxxxxxx	**********	//////////
----------	00000000000	xxxxxxxxxxxxx	**********	//////////

PAIN CHART

PLEASE MARK ON THE PAIN SCALE FROM ZERO TO 10 THE PAIN YOU FEEL WITH THIS CONDITION. 10 BEING THE WORST PAIN YOU HAVE FELT WITH THIS CONDITION.



NECK-SHOULDER-ARM PAIN
ON A SCALE OF ZERO TO 10, I RATE MY DISCOMFORT AS FOLLOWS

1 2 3 4 5 6 7 8 9 10

(0=NO PAIN; 10=SEVERE PAIN)

MID BACK PAIN
ON A SCALE OF ZERO TO 10, I RATE MY DISCOMFORT AS FOLLOWS

1 2 3 4 5 6 7 8 9 10

(0=NO PAIN; 10=SEVERE PAIN)

LOW BACK AND LEG PAIN
ON A SCALE OF ZERO TO 10, I RATE MY DISCOMFORT AS FOLLOWS

1 2 3 4 5 6 7 8 9 10

(0=NO PAIN; 10=SEVERE PAIN)