

# Health History Form

CASE NO.

Fill out this form, print it, and bring it with you on your first visit to our office. Date:

Please fill out the following form with as much detail as possible.

Name:

Address:

City:  State:  Zip:

Home Number:  Office Number:

E-mail Address:

Age:  Date of Birth:  Occupation:  Sex: Male  Female

Weight:  Referred By:

Married  S  W  D  Children:  Name of Spouse:

Employer:  Address:

Is any other member 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 symptoms - please be as specific as you can. Ask the doctor or nurse 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  Day and date you last worked:

Have you ever had this condition before or a similar condition? Yes  No

When?

What positions or activities aggravate your condition?

What positions or activities relieve your condition?

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:

Please send a report to my family physician. Yes  No

Will this case be covered by any insurance company?

Major Medical  Auto  Blue Cross / Blue Shield  Workers' Compensation   
Medicare  Other

Have you ever been in any accidents, auto, fall down stairs, fall from ladder, etc (include childhood injuries)? Yes  No

When?

Are you allergic to anything you are aware of? Yes  No

Are you presently taking any medication (aspirin included)? Yes  No

If "Yes", name them:

Have you ever broken any bones? (fractures) Yes  No  Any dislocations? Yes  No

What operations have you had?  Year   
 Year   
 Year

Have you had any cosmetic surgery, breast implants. etc.? Yes  No  Year

Have you had any surgery to replace hip, knee, etc.? Yes  No  Year

Give dates you have had any of the following: (if exact date is unknown, give approximate date)

Blood Test  Urinalysis   
 MRI  CT Scan  Ultrasound   
 Radiation Treatment  X-Ray examination

Other special treatment:

At what hospital or office were these tests taken at?

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

Do you faint easily? Yes  No

Do you take vitamins? Yes  No  If Yes, please list them

Do you exercise regularly? Yes  No  What kind of exercise?

Habits: (please check)

Cigarettes?  Quantity  Coffee?  Quantity   
 Alcohol?  Quantity  Tea?  Quantity

Hobbies:

Have you been treated for any health condition by a physician in the past year? Yes  No

If Yes, what condition?

Have you lost or gained weight in the past year? Yes  No

Use this space for any additional information you may wish to discuss:

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 conditions in the past (prior to the past 12 months).

|                          | Now<br>N              | Past<br>P             |                 | Now<br>N              | Past<br>P             |
|--------------------------|-----------------------|-----------------------|-----------------|-----------------------|-----------------------|
| Headaches_____ Frequency | <input type="radio"/> | <input type="radio"/> | Loss of Balance | <input type="radio"/> | <input type="radio"/> |
| Neck Pain                | <input type="radio"/> | <input type="radio"/> | Fainting        | <input type="radio"/> | <input type="radio"/> |

|                            |                       |                       |                        |                       |                       |
|----------------------------|-----------------------|-----------------------|------------------------|-----------------------|-----------------------|
| Stiff Neck                 | <input type="radio"/> | <input type="radio"/> | Loss of Smell          | <input type="radio"/> | <input type="radio"/> |
| Sleeping Problems          | <input type="radio"/> | <input type="radio"/> | Loss of Taste          | <input type="radio"/> | <input type="radio"/> |
| Back Pain                  | <input type="radio"/> | <input type="radio"/> | Diarrhea               | <input type="radio"/> | <input type="radio"/> |
| Nervousness                | <input type="radio"/> | <input type="radio"/> | Feet Cold              | <input type="radio"/> | <input type="radio"/> |
| Tension                    | <input type="radio"/> | <input type="radio"/> | Hands Cold             | <input type="radio"/> | <input type="radio"/> |
| Irritability               | <input type="radio"/> | <input type="radio"/> | Arthritis              | <input type="radio"/> | <input type="radio"/> |
| Chest Pains                | <input type="radio"/> | <input type="radio"/> | Muscle Spasms          | <input type="radio"/> | <input type="radio"/> |
| Dizziness                  | <input type="radio"/> | <input type="radio"/> | Frequent Colds         | <input type="radio"/> | <input type="radio"/> |
| Shoulder / Neck / Arm Pain | <input type="radio"/> | <input type="radio"/> | Stomach Upset          | <input type="radio"/> | <input type="radio"/> |
| Pins & Needles in Arms     | <input type="radio"/> | <input type="radio"/> | Constipation           | <input type="radio"/> | <input type="radio"/> |
| Pins & Needles in Legs     | <input type="radio"/> | <input type="radio"/> | Cold Sweats            | <input type="radio"/> | <input type="radio"/> |
| Numbness in Fingers        | <input type="radio"/> | <input type="radio"/> | Fever                  | <input type="radio"/> | <input type="radio"/> |
| Numbness in Toes           | <input type="radio"/> | <input type="radio"/> | Sinus Problems         | <input type="radio"/> | <input type="radio"/> |
| High Blood Pressure        | <input type="radio"/> | <input type="radio"/> | Diabetes               | <input type="radio"/> | <input type="radio"/> |
| Difficulty Urinating       | <input type="radio"/> | <input type="radio"/> | Hemorrhoids            | <input type="radio"/> | <input type="radio"/> |
| Allergies                  | <input type="radio"/> | <input type="radio"/> | Leg Cramps             | <input type="radio"/> | <input type="radio"/> |
| Weakness in Arms           | <input type="radio"/> | <input type="radio"/> | Colitis                | <input type="radio"/> | <input type="radio"/> |
| Weakness in Legs           | <input type="radio"/> | <input type="radio"/> | Gall Bladder           | <input type="radio"/> | <input type="radio"/> |
| Shortness of Breath        | <input type="radio"/> | <input type="radio"/> | Indigestion            | <input type="radio"/> | <input type="radio"/> |
| Fatigue                    | <input type="radio"/> | <input type="radio"/> | Belching               | <input type="radio"/> | <input type="radio"/> |
| Depression                 | <input type="radio"/> | <input type="radio"/> | Vomiting               | <input type="radio"/> | <input type="radio"/> |
| Lights Bother Eyes         | <input type="radio"/> | <input type="radio"/> | Shoulder Pain          | <input type="radio"/> | <input type="radio"/> |
| Loss of Memory             | <input type="radio"/> | <input type="radio"/> | Swelling Joints        | <input type="radio"/> | <input type="radio"/> |
| Ears Ring                  | <input type="radio"/> | <input type="radio"/> | Knee Pain              | <input type="radio"/> | <input type="radio"/> |
| Face Flushed               | <input type="radio"/> | <input type="radio"/> | Hay Fever              | <input type="radio"/> | <input type="radio"/> |
| Buzzing in Ears            | <input type="radio"/> | <input type="radio"/> | Menstrual Difficulties | <input type="radio"/> | <input type="radio"/> |

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.

|  |     |                       |    |                       |
|--|-----|-----------------------|----|-----------------------|
| Do you have chest pain?                                  | Yes | <input type="radio"/> | No | <input type="radio"/> |
| Do you have any change in bowel or bladder habits?       | Yes | <input type="radio"/> | No | <input type="radio"/> |
| Do you have a sore that does not heal?                   | Yes | <input type="radio"/> | No | <input type="radio"/> |
| Do you have any unusual bleeding or discharge?           | Yes | <input type="radio"/> | No | <input type="radio"/> |
| Do you have any thickening in your breasts or elsewhere? | Yes | <input type="radio"/> | No | <input type="radio"/> |

- 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

Notes:

Are you taking any medications or over-the counter drugs? Yes  No

Please indicate type (aspirin, etc.)

What was the date of onset of your last menses?

#### SOCIAL HISTORY

Smoker  YES, or  NO (If "Yes", how many packs, and frequency)

Alcohol  YES, or  NO (If "Yes", how much drank, which liquid, and frequency)

#### FAMILY HISTORY

Has your mother or father had any of the following:

Put an M for mother, F for father, and B for both

| M                     | F                     | B                     |                      | M                     | F                     | B                     |                           |
|-----------------------|-----------------------|-----------------------|----------------------|-----------------------|-----------------------|-----------------------|---------------------------|
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | High Blood Pressure  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Ulcer or Stomach Problems |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Heart Attack         | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Stroke                    |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Emphysema            | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Arthritis - Rheumatism    |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Seizures-Convulsions | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Mental Illness            |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | HIV Positive         | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Thyroid Disease           |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Asthma               | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Circulation Problems      |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Diabetes             | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Cancer                    |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Kidney Disease       | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Osteoporosis              |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Pacemaker            |                       |                       |                       |                           |

Comments:

Print this form and bring it with you on your first visit to our office.