

## Patient Health History

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: M F  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ Marital Status: S M D W Number of Children: \_\_\_\_\_  
 Occupation: \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
 Employer: \_\_\_\_\_ Driver's License Number: \_\_\_\_\_  
 Spouse's Name: \_\_\_\_\_ Spouse's Age: \_\_\_\_\_ Spouse's Date of Birth: \_\_\_\_\_  
 Spouse's Occupation: \_\_\_\_\_ Spouse's Social Security Number: \_\_\_\_\_  
 Spouse's Employer: \_\_\_\_\_ Spouse's Phone (Work): \_\_\_\_\_  
 Insured's Name: \_\_\_\_\_ Insured's Phone: \_\_\_\_\_ Insured's Date of Birth: \_\_\_\_\_  
 Insurance Company: \_\_\_\_\_ Spouse's Insurance Company: \_\_\_\_\_  
 How did you hear about this office: \_\_\_\_\_ Referred by: \_\_\_\_\_  
 Family Dr's Name: \_\_\_\_\_ Address: \_\_\_\_\_  
 Send report? Yes No  
 Past Chiropractic Care: Yes No When? \_\_\_\_\_ Doctor's Name: \_\_\_\_\_ Results: \_\_\_\_\_

Purpose of this appointment: \_\_\_\_\_  
 Are your present problems due to an injury? Yes No On Job Auto Accident Personal Injury Other: \_\_\_\_\_  
 Has the accident been reported? Yes No To Employer Auto Carrier Other: \_\_\_\_\_  
 Are you now or have you ever been disabled? (Service or Work)? Yes No When? \_\_\_\_\_  
 Have you retained an attorney? Yes No Name & Address: \_\_\_\_\_

**What is your current work status?**

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> Full time, no restrictions   | <input type="checkbox"/> Full time, restrictions | <input type="checkbox"/> Full time Homemaker | <input type="checkbox"/> Full time student |
| <input type="checkbox"/> Part time, no restrictions   | <input type="checkbox"/> Part time, restrictions | <input type="checkbox"/> Retired             | <input type="checkbox"/> Unemployed        |
| <input type="checkbox"/> Off work due to restrictions | <input type="checkbox"/> Other _____             |  |  |

**Restrictions:** Off work: Yes No Previously From: \_\_\_\_\_ to \_\_\_\_\_  
 Light duty: Yes No Previously (If yes, what are/were your restrictions?) \_\_\_\_\_  
 Do/did you require outside help at home?  
Yes No (If yes, what help do/did you need?) \_\_\_\_\_

List any accidents or falls and dates: Auto: \_\_\_\_\_ Recreation: \_\_\_\_\_  
Sports: \_\_\_\_\_ Work Related: \_\_\_\_\_ Other: \_\_\_\_\_

List any broken bones (fractures) or dislocations: \_\_\_\_\_

Ever on crutches? Yes No Why? \_\_\_\_\_

Were you ever knocked unconscious? Yes No (If yes, please explain): \_\_\_\_\_

Have you ever had X-rays taken? Yes No When? \_\_\_\_\_ By Whom? \_\_\_\_\_

For what ailments were these X-rays made? \_\_\_\_\_

Do you wear orthotics or heel lifts? Yes No Fitted by whom? \_\_\_\_\_ When? \_\_\_\_\_

Do you suffer from any condition other than that for which you are now consulting us? Yes No \_\_\_\_\_

Are you presently taking any medication, prescription, over-the-counter, home remedies, vitamins, minerals, etc?  
 (Please list) \_\_\_\_\_

### OPERATIONS AND PROCEDURES

<b>DATE</b>	<b>DATE</b>	<b>DATE</b>	<b>DATE</b>
_____ Vaccinations	_____ Spinal Taps/Injections	_____ Sinus	_____ Hernia
_____ Tonsillectomy	_____ Appendectomy	_____ Thyroid	_____ Stomach
_____ Female Organs	_____ Gall Bladder	_____ Back Operation	_____ Rectal Surgery
Other _____		<input type="checkbox"/> I have never had any operations or surgeries	

Please check the correct box for each item below. Check at least one box for each sign or symptom listed.

Never Presently <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<b>GENERAL SYMPTOMS</b> Allergy(What) _____ _____ Bronchitis Chills (Constant) Convulsions Dizziness Fainting Fatigue Headache Loss of Sleep Loss of Weight Nervousness Night Sweats Numbness or Pain in arms/legs/hands Wheezing <b>MUSCLES &amp; JOINTS</b> Backache Foot Trouble Hernia Pain Between Shoulders Painful Tail Bone Stiff Neck Spinal Curvature Swollen Joints Tremors Twitching	Never Presently <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<b>GASTRO-INTESTINAL</b> Belching or Gas Colon Trouble Constipation Diarrhea Gall Bladder Trouble Hemorrhoids (piles) Jaundice Liver Trouble Nausea Stomach Pain Vomiting Vomiting Blood Heart Burn Bloody Stools Acid Reflux Irritable Bowel <b>CARDIO-VASCULAR</b> High Blood Pressure Low Blood Pressure Chest Pain Heart Trouble Poor Circulation Rapid Heart Slow Heart Strokes Swelling Ankles Varicose Veins	Never Presently <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<b>EYE/EAR NOSE/THROAT</b> Asthma Deafness Earache Ear Discharge Ear Noises Thyroid Problems Frequent Colds Hay Fever Nasal Obstruction Nose Bleeds Pain in Eyes Poor Vision Blurred Vision Sinusitis Sore Throats Tonsillitis <b>SKIN OR ALLERGIES</b> Bruising Easily Dryness Eczema Hives or Allergy Itching Sensitive Skin Skin Eruptions	Never Presently <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<b>RESPIRATORY</b> Chest Pain Chronic Cough Difficulty Breathing Spitting Blood Spitting Phlegm  <b>GENITO-URINARY</b> Bed Wetting Blood in Urine Frequent Urination Inability to Control Urine Kidney Infection Kidney Stones Painful Urination Prostate Trouble <b>FOR FEMALES ONLY</b> Cramps Hot Flashes Irregular Cycle Painful Periods Vaginal Discharge Yes <input type="checkbox"/> No <input type="checkbox"/> Pregnant at this Time _____ Last Pap Date _____ Last Menstrual Cycle
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**DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?**

<input type="checkbox"/> Appendicitis	<input type="checkbox"/> Anemia	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Measles
<input type="checkbox"/> Goiter	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Mumps	<input type="checkbox"/> Influenza	<input type="checkbox"/> Mental Disorder
<input type="checkbox"/> Polio	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Pleurisy	<input type="checkbox"/> Lumbago	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Eczema	<input type="checkbox"/> Whooping Cough	<input type="checkbox"/> Cancer	<input type="checkbox"/> Venereal Disease	<input type="checkbox"/> HIV Positive

<b>HABITS</b> <input type="checkbox"/> Smoking Packs/day: _____ <input type="checkbox"/> Drinking Alcohol: (Cups/day) _____ <input type="checkbox"/> Coffee Cups/Day: _____ <input type="checkbox"/> Soft Drink Bottles or Cans/Day: _____ <input type="checkbox"/> Water Cups/Day: _____	<b>EXERCISE</b> <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Daily Type: _____	<b>FAMILY HISTORY</b> Diabetes    Kidney    Cancer    Back Mother <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Father <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Brother(s), # of _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sister(s), # of _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
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I understand and agree that if I have health and/or accident insurance, these policies are an arrangement between the insurance carrier and myself. Further, I understand that this health care provider will prepare reports and forms to assist in reimbursement from the insurance company. Any amount authorized to be paid directly to this office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are my personal responsibility for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

I hereby authorize the doctor to examine and treat my condition as he deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed the amount paid to the Doctor for imaging is for examination only and the negatives will remain the property of this office, being on file where they may be viewed.

**Patient's/Guardian's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_