



Patient Health History

Name _____ Date _____

Date of Birth _____ Age _____ Height _____ Weight _____ Blood Type _____

Occupation _____

What brings you to our office? _____

List your major health problems/concerns:

1. _____

2. _____

3. _____

4. _____

Describe the causes of these concerns (if known or suspected): _____

Have you had the same (or similar) problem before (*circle one*)? **Y** / **N**

What activities aggravate your problem(s)? _____

What activities improve your problem(s)? _____

Are your problems getting progressively worse? **Y** / **N**

Are your problems interfering with (*check all that apply*):

Work Daily Routine Sleep Other _____

If your condition involves pain please characterize type:

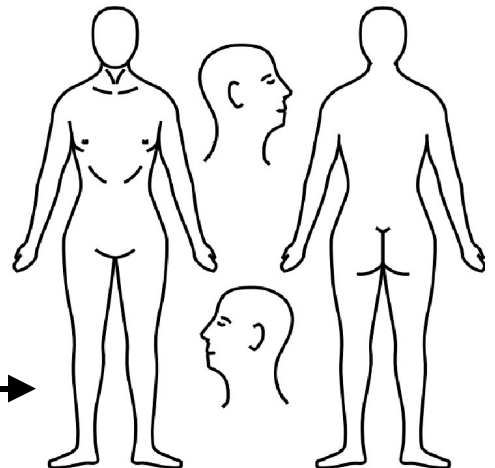
Ache Sharp Radiating Constant Intermittent

Please rate the amount of pain you are generally experiencing:

(*circle one*) mild 1 2 3 4 5 6 7 8 9 10 severe

Please use the diagram to the right to indicate areas of involvement →

(*mark: P for pain, T for tightness, N for numbness*).



Previous Treatment for Health Problems

Were you previously treated for the above problems? **Y / N**

*(if no, skip to **Health Maintenance Update** section below)*

Name of practitioner _____

Date first seen _____ Date last seen _____

List tests that were done, including X-rays _____

List pertinent test results _____

Condition or diagnosis _____

How was the condition treated _____

Results of treatment: Good Fair Poor

Please list below other practitioners seen for this condition: (or check here for none _____)

Name	Date (approx.)	Testing/Treatment
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

Additional remarks about previous treatment _____

Current primary care physician _____

Do you suffer from any other health problems from which you are not seeking consultation with us?

Y / N If yes, please itemize below:

Condition	Date of onset (approx.)	Practitioner
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

Health Maintenance Update

Please indicate approximate dates and results of last:

Physical exam _____

Spinal exam _____

Dental exam _____

Cholesterol profile _____

Other blood tests _____

Chest X-ray _____

Spinal X-ray _____

Bone density (DEXA) scan _____

Mammogram _____

Eye exam _____

Colonoscopy or flexible sigmoidoscopy _____

Other _____

List all medications you are currently using, or have used recently. Include all over-the-counter medications. List dosages and approximate length of time you have used each medication:

List (include name, brand, dosage) all vitamins, minerals, herbs, and other natural products you are currently using:

List medication/supplement/environmental allergies or intolerances and associated reactions:

List past or present exposure to harmful chemicals:

Surgical History

Please list all major and minor surgeries you have undergone with approximate dates:

Previous Chiropractic Care

Have you previously had chiropractic care? **Y / N** (if no, skip to **Serious Accidents** section below)

Chiropractor _____

Date first seen _____ Date last seen _____

Under treatment for what condition at that time _____

Were X-rays taken? **Y / N** If yes, please indicate approximate date and region(s) X-rayed:

Cause of condition as explained by doctor _____

Results of treatment: Good Fair Poor

Serious Accidents and Falls

Have you ever been in an auto accident? **Y / N** Date(s) _____

Describe _____

Have you had any significant sports injuries? **Y / N** Date(s) _____

Describe _____

Have you had any work accidents? **Y / N** Date(s) _____

Describe _____

Please describe any other accidents, falls, or injuries (include dates):

Please list all fractures you have sustained and when they occurred:

Early Health History

List any known problems your mother had during her pregnancy with you (illness, stress, medication, smoking, alcohol, traumatic delivery):

Were you breast fed? **Y / N**. If yes, please indicate duration if known _____

Was your home life as a child loving/supportive? **Y / N**

If there were significant stresses please describe _____

Please check if you had any of the following childhood illnesses:

Frequent ear infections Colic Eczema Recurrent colds Bronchitis

Pneumonia Meningitis Other _____

As a child were you on frequent or prolonged antibiotic therapy? **Y / N**

Did you receive immunizations? **Y / N**

Did you experience any adverse reactions to immunizations? **Y / N / NA**

If yes, please describe _____

Please check all of the following conditions that you have experienced:

- | | | |
|---|-------------------------------|----------------------------------|
| — Alcohol/drug addiction | — Diabetes | — Mental health problems |
| — Allergies | — Emphysema | — Pneumonia |
| — Anemia | — Environmental sensitivities | — Sexually transmitted infection |
| — Anxiety, reoccurring | — Epilepsy | — Sinus congestion, chronic |
| — Asthma | — Fatigue, chronic | — Skin problems |
| — Blood fats, high (cholesterol, triglycerides) | — Gallstones | — Thyroid disorder |
| — Blood pressure, high | — Headaches, reoccurring | — Ulcer |
| — Blood pressure, low | — Heart attack | — Urination problems |
| — Bone loss | — Heart disease | — Other (please describe): |
| — Cancer | — Heart palpitations | _____ |
| — Depression | — Insomnia | _____ |
| | — Kidney disease | |

Female Health History

Age at first period _____ Date of last period _____
Number of pregnancies _____ Number of live births _____
Date of last Pap test _____ History of abnormal Pap tests? **Y / N**
History of irregular periods? **Y / N** Menstrual cycle length: _____ days.
Duration of menstrual period: _____ days.
Do you experience significant menstrual cramping? **Y / N**
Is heavy bleeding a problem? **Y / N**
Do you have a history of endometriosis? **Y / N**
Do you have a history of yeast infections? **Y / N**
Do you have a history of infertility? **Y / N**
Do you have excessive unwanted hair growth? **Y / N**
Do you have a tendency toward premenstrual syndrome? **Y / N**

If yes, please describe symptoms: _____

Do you have a family history of (check all that apply): breast cancer ovarian cancer osteoporosis

Describe any current menstrual or menopausal symptoms or concerns:

_____ Describe any current breast problems: _____

Did you breast feed? **Y / N** *If yes, please indicate duration for each child:* _____

Digestive Function

Describe any food intolerances you have: _____

_____ Describe any digestive problems: _____

Your usual bowel movement frequency is (check one):

- >2 times daily 1 time daily 1time every 2 days <1 time every 2 days.

Do you usually have to strain to have a bowel movement? **Y / N**
 Are your bowel movements chronically loose? **Y / N**
 Do you ever have blood with bowel movements? **Y / N**
 Are your stools ever black or tarry? **Y / N**
 When was the last time you received antibiotics? _____

Family Health History

Review the conditions below. Indicate if a family member has ever had a condition with an 'X' in the appropriate space. Leave blank any spaces that do not apply.

CONDITION	Father	Mother	Spouse	Brother(s)	Sister(s)	Children
	Age ____	Age ____	Age ____	Age(s)____	Age(s)____	Age(s)____
Acne						
Alcoholism/addiction						
Allergies/hay fever						
Alzheimer's Disease						
Arthritis						
Asthma						
Bedwetting						
Cancer (<i>specify type</i>)						
Depression						
Diabetes						
Digestive problems						
Ear infections						
Female problems						
Headaches						
Heart disease						
High blood pressure						
Insomnia						
Kidney problems						
Liver disease						
Mental health problems						
Migraine						
Muscle pain/cramps						
Osteoporosis						
Spinal curve						
Thyroid problems						
Other (<i>specify</i>)						
Other (<i>specify</i>)						
If any of the above family members are deceased, please list their age at death and specify cause of death.						
Other pertinent family history:						

Stress Factors

Please indicate if any of the major stresses listed below apply to you (*check all that apply*):

- Job New retirement New baby Change of marital status Health problems
- Family stress Financial concerns Abusive relationship Other: _____.

Please describe the quality of major relationships in your life: _____

Indicate job satisfaction (if applicable): Excellent Good Fair Poor

Have you experienced physical, emotional, sexual, or verbal abuse? **Y / N**

Lifestyle Habits

Describe your sleep pattern: Time arise _____ Time retire _____ Naps? **Y / N**

Your quality of sleep is: Well-rested Tired upon awakening Awaken during night

Do you: Sleep in total darkness Sleep near electric clock, outlet, or other electronic device

Your typical sleep position is: Side Back Stomach Is your mattress firm? **Y / N**

Pillow type (*check all that apply*): Firm Soft Thick Thin Feather Synthetic Orthopedic

What is the frequency of your vacations: _____ times / year.

How frequently do you travel: Annually Semi-annually Monthly Weekly

Do you live/work in a damp or moldy home/office? **Y / N**

Do you exercise? **Y / N**

If *yes*... Type: _____ Frequency: _____ times per week/month (*circle one*).

How do you relax or relieve stress? _____

Do you use tobacco? **Y / N** If *yes*, list amount you smoke/chew per day and week _____

Years using tobacco _____, if you no longer use it, when did you quit _____

Do you use recreational drugs? **Y / N** If *yes*, list type and frequency _____

Did you formerly use recreational drugs? **Y / N** If *yes*, specify _____

Diet History

Describe your typical:

breakfast _____ lunch _____

dinner _____ snack _____

How frequently do you dine out: Daily Weekly Monthly Rarely/never

How frequently do you eat fast food: Daily Weekly Monthly Rarely/never

How much water do you drink daily: < 1 qt. 1 qt. 2 qt. > 2qt.

Is it filtered water? **Y / N**

Foods you avoid and why (*i.e.* allergies, diet, dislike): _____

Foods you crave: _____

Do you have (or have you had) an eating disorder? **Y / N**

Do you drink coffee? **Y / N** if *yes*, how many cups daily of decaf _____ and caffeinated _____

Do you drink tea? **Y / N** if *yes*, what kind _____ and how many cups do you drink daily _____

Do you drink soda? **Y / N** if *yes*, what kind _____ and how many do you drink daily _____

Do you drink alcohol? **Y / N** if *yes*, list type and amount per day and week _____

Do you have (or have you had) a problem with alcohol overuse? **Y / N**