

# HEALTH HISTORY

<b>Name</b> <small>(First, MI, Last)</small>		<input type="checkbox"/> M <input type="checkbox"/> F	<b>DOB:</b>	<b>Age:</b>	
<b>Address:</b>	<i>Street:</i>	<i>City:</i>	<i>State:</i>	<i>Zip:</i>	
<b>Marital status:</b>	<input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed				
<b>Primary Doctor:</b>		<b>Date of last physical exam:</b>			
<b>Previous Chiropractor:</b>		<b>Date of last chiropractic exam:</b>			

## PERSONAL HEALTH HISTORY

<b>Childhood Illness:</b>	<input type="checkbox"/> Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Rubella <input type="checkbox"/> Chickenpox <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Polio <input type="checkbox"/> Other
<b>List any medical problems that other doctors have diagnosed:</b>	<b>Check here if none:</b> <input type="checkbox"/> None

<b>Please list all Surgeries and Hospitalizations (use back if necessary)</b>		<b>Check here if none:</b> <input type="checkbox"/> None
Year	Reason	Outcome

<b>Have you ever been diagnosed with cancer? If yes, please list below with type, date, type of treatment.</b>				<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Type:	Date:	Type of Treatment:					
Type:	Date:	Type of Treatment:					

<b>Have you ever been diagnosed with any of the following:</b>	<input type="checkbox"/> Diabetes <input type="checkbox"/> Blood Pressure <input type="checkbox"/> Stroke <input type="checkbox"/> T.I.A. <input type="checkbox"/> Asthma <input type="checkbox"/> Osteoporosis <input type="checkbox"/> None
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<b>List your prescribed drugs and over-the-counter drugs, including vitamins and supplements (use back if necessary)</b>		
1.	4.	7.
2.	5.	8.
3.	6.	9.

<b>Please list any past injuries, accidents or traumas. (use back if necessary)</b> (car accidents, falls, sports injuries, work injuries, etc)		
Year	Type of Injury	Outcome

## HEALTH HABITS

<b>Exercise</b>	<input type="checkbox"/> Sedentary (No exercise)										
	<input type="checkbox"/> Mild exercise (i.e., climb stairs, walk 3 blocks, golf)										
	<input type="checkbox"/> Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)										
	<input type="checkbox"/> Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)										
<b>Diet</b>	Would you consider your diet healthy?					<input type="checkbox"/>	Yes	<input type="checkbox"/>	No		
	Do you eat the recommended 10 servings of fruits and vegetables per day?					<input type="checkbox"/>	Yes	<input type="checkbox"/>	No		
<b>Fluids</b>	How many 8-oz. glasses of water do you drink per day?		<input type="checkbox"/> None	<input type="checkbox"/> 1-2	<input type="checkbox"/> 3-4	<input type="checkbox"/> 5-6	<input type="checkbox"/> 7-8	<input type="checkbox"/> Over 8			
<b>Caffeine</b>	<input type="checkbox"/> None		<input type="checkbox"/> Coffee		<input type="checkbox"/> Tea		<input type="checkbox"/> Cola				
	# of cups/cans per day?										
<b>Alcohol</b>	Do you drink alcohol?							<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
	How many drinks per week?										
<b>Tobacco</b>	Do you use tobacco?							<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
	<input type="checkbox"/> Cigarettes - pks./day		<input type="checkbox"/> Chew - #/day		<input type="checkbox"/> Pipe - #/day		<input type="checkbox"/> Cigars - #/day				
<b>Drugs</b>	Do you currently use recreational or street drugs?							<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

## OCCUPATION

<b>Occupation</b>	Type of work you perform:	<input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Disabled <input type="checkbox"/> Retired <input type="checkbox"/> Student <input type="checkbox"/> None
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## FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
<b>Father</b>			<b>Children</b>	<input type="checkbox"/> M <input type="checkbox"/> F	
<b>Mother</b>				<input type="checkbox"/> M <input type="checkbox"/> F	
<b>Sibling</b>	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> M <input type="checkbox"/> F	
	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> M <input type="checkbox"/> F		<b>Grandmother</b> <i>Maternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		<b>Grandfather</b> <i>Maternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		<b>Grandmother</b> <i>Paternal</i>		
<input type="checkbox"/> M <input type="checkbox"/> F		<b>Grandfather</b> <i>Paternal</i>			

## REVIEW OF SYSTEMS

Check if you have, or have had, any symptoms in the following areas within the past 6 months.

<b>MUSCULO-SKELETAL CODE</b>	<input type="checkbox"/> Low Back Pain <input type="checkbox"/> Pain Between Shoulders <input type="checkbox"/> Neck Pain <input type="checkbox"/> Arm Pain <input type="checkbox"/> Joint Pain/Stiffness <input type="checkbox"/> Walking Problems <input type="checkbox"/> Clicking Jaw <input type="checkbox"/> General Stiffness <input type="checkbox"/> Other: _____
<b>NERVOUS SYSTEM CODE</b>	<input type="checkbox"/> Nervous <input type="checkbox"/> Numbness <input type="checkbox"/> Paralysis <input type="checkbox"/> Dizziness <input type="checkbox"/> Forgetfulness <input type="checkbox"/> Stress <input type="checkbox"/> Confusion <input type="checkbox"/> Depression <input type="checkbox"/> Fainting <input type="checkbox"/> Convulsions <input type="checkbox"/> Cold / Tingling Extremities
<b>GENERAL CODE</b>	<input type="checkbox"/> Fatigue <input type="checkbox"/> Allergies <input type="checkbox"/> Loss of Sleep <input type="checkbox"/> Fever <input type="checkbox"/> Headaches <input type="checkbox"/> Migraines
<b>GASTRO-INTESTINAL CODE</b>	<input type="checkbox"/> Poor / Excessive Appetite <input type="checkbox"/> Excessive Thirst <input type="checkbox"/> Frequent Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Liver Problems <input type="checkbox"/> Gall Bladder Problems <input type="checkbox"/> Weight Trouble <input type="checkbox"/> Cramps <input type="checkbox"/> Gas/Bloating After Meals <input type="checkbox"/> Black/Bloody Stool <input type="checkbox"/> IBS <input type="checkbox"/> Colitis
<b>GENITO-URINARY CODE</b>	<input type="checkbox"/> Bladder Trouble <input type="checkbox"/> Painful/Excessive Urination <input type="checkbox"/> Discolored
<b>C-V-R CODE</b>	<input type="checkbox"/> Chest Pain <input type="checkbox"/> Short Breath <input type="checkbox"/> Blood Pressure Problems <input type="checkbox"/> Irregular Heartbeat <input type="checkbox"/> Heart Problems <input type="checkbox"/> Lung Problems <input type="checkbox"/> Congestion <input type="checkbox"/> Varicose Veins <input type="checkbox"/> Ankle Swelling <input type="checkbox"/> Stroke
<b>EENT CODE</b>	<input type="checkbox"/> Vision Problems <input type="checkbox"/> Dental Problems <input type="checkbox"/> Sore Throat <input type="checkbox"/> Ear Aches <input type="checkbox"/> Hearing Difficulty
<b>MALE / FEMALE CODE</b>	<input type="checkbox"/> Menstrual Irregularity <input type="checkbox"/> Cramps <input type="checkbox"/> Breast Pain <input type="checkbox"/> Lumps <input type="checkbox"/> Prostate Problems <input type="checkbox"/> Other _____ <input type="checkbox"/> First day of your last menstrual period: _____ <input type="checkbox"/> Are You Pregnant: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure

## REASON FOR YOUR VISIT TODAY

Area of Problem(s):	<i>Primary:</i>	<i>Secondary:</i>	<i>Tertiary:</i>
What professionals have you consulted for this condition?	<input type="checkbox"/> Chiropractor	<input type="checkbox"/> MD/PCP	<input type="checkbox"/> Physical Therapy
	<input type="checkbox"/> X-Rays	<input type="checkbox"/> MRI	<input type="checkbox"/> CT Scan
	<input type="checkbox"/> None	<input type="checkbox"/> MRI	<input type="checkbox"/> Bone Scan
	<input type="checkbox"/> None	<input type="checkbox"/> MRI	<input type="checkbox"/> Pain Injections
Have you had any of the following for this condition:	<input type="checkbox"/> None	<input type="checkbox"/> MRI	<input type="checkbox"/> Pain Injections
List date condition began?	Is condition: <input type="checkbox"/> Auto Related <input type="checkbox"/> Job Related <input type="checkbox"/> Home Injury <input type="checkbox"/> Fall <input type="checkbox"/> Chronic		