Personal Health History

Name _____

Address _____

City _____ State _____ Zip _____

Phone: (H) _____ (W) _____

Cell: _____ Provider: _____

E-mail _____

Date of Birth _____ (Age _____)

Occupation _____

Marital Status S M D W

Emergency Contact _____

Relation to EC _____

Person who referred you _____

Please Circle All That Apply

1. Birth/Infancy		***Comments***
Long Delivery?	Y	_____
Difficult Delivery?	Y	_____
Forceps?	Y	_____
Caesarian?	Y	_____
Breach?	Y	_____
Home birth?	Y	_____
Meds during delivery?	Y	_____
Induced Labor?	Y	_____
Breastfed?	Y	_____
Vaccines?	Y	_____

2. Growth and Development		***Comments***
Fall out of bed?	Y	_____
Bang your head?	Y	_____
Childhood sickness?	Y	_____
Have any Accidents?	Y	_____
Have Surgery?	Y	_____
Medications/Vaccines?	Y	_____
Fall learning to walk?	Y	_____
Bullied by siblings?	Y	_____
Physical/Sexual abuse?	Y	_____
Other traumas?	Y	_____

3. Current Health Habits		***Comments***
Did/do you smoke?	Y	_____
Did/do you drink alcohol?	Y	_____
Do you eat sugary foods?	Y	_____
OTC or Prescription Drugs?	Y	_____
Illegal/Recreational Drugs?	Y	_____
Exercise regularly?	Y	_____

Sleeping position: R Side L Side Back Stomach

		Comments
Have sleeping problems?	Y	_____
Have occupational stress?	Y	_____
Have physical stress?	Y	_____
Have mental stress?	Y	_____
Have hobbies?	Y	_____
Play sports?	Y	_____

Hours of sleep: _____ Quality: Good Fair Poor

Would you answer "yes" to any of these for your spouse or children? Y N

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Current Health Condition

Present Complaint or Crisis? If no current crisis, what is the main reason for your visit today?

_____

Pain or Problem started on _____ What caused it? _____

Complaint is: ❒ Better ❒ Worse ❒ Same ❒ Comes and goes Does it travel? _____

What makes it worse?		What makes it better?	
☐Driving	☐Breathing	☐Chiropractic	☐Heat
☐Walking	☐Coughing	☐Rest	☐Stretching
☐Sitting	☐Sleeping	☐Lying Down	☐Massage
☐Bending	☐Working	☐Sitting	☐Medication
☐Standing	☐Exercising	☐Standing	☐Ice/Cold
☐Bowel Movement	☐Other _____	☐Walking	☐Other _____

Rate your pain TODAY: 1☐ (best) 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐ (worst)

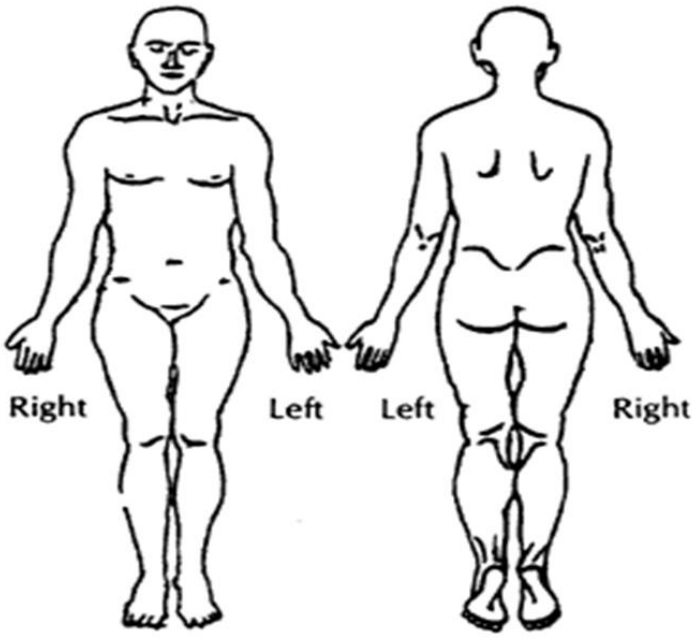
Rate your AVERAGE pain: 1☐ (best) 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐ (worst)

Is it worse during certain times of the day? _____ Better? _____

Is this condition interfering with: Work ☐ Sleep ☐ Daily Routine ☐ Other Activities ☐

Other doctors seen? _____ Imaging? _____

Any home remedies? _____



PAIN DIAGRAM

Please mark the location(s) of your pain using the following symbols:

N = numbness/tingling
^ = sharp/stabbing
B = burning
S = shooting/travelling
A = aching
O = other (describe)
T = tightness

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Other symptoms:

❒ Headaches	❒ Face Flushed	❒ Light Bothers Eyes	❒ Feet Cold
❒ Neck Pain	❒ Neck Stiff	❒ Loss of Memory	❒ Hands Cold
❒ Sleeping Problems	❒ Pins & Needles in Legs	❒ Ears Ringing	❒ Stomach Upset
❒ Back Pain	❒ Pins & Needles in Arms	❒ Fever	❒ Constipation
❒ Nervousness	❒ Numbness in Fingers	❒ Fainting	❒ Loss of Balance
❒ Tension	❒ Numbness in Toes	❒ Cold Sweats	❒ Buzzing in Ear
❒ Irritability	❒ Shortness of Breath	❒ Loss of Smell	
❒ Chest Pains	❒ Fatigue	❒ Loss of Taste	
❒ Dizziness	❒ Depression	❒ Diarrhea	

Have you had any serious accidents or falls? Y N _____

_____

What medications or supplements are you taking? _____

Have you had surgery? Y N What/When? _____

What side effects have you experienced from the drugs and surgery? _____

Previous chiropractic care? Y N Office: _____ Approximate date of last visit? _____

Family History:

	Heart Disease	Arthritis	Cancer	Diabetes	Obesity	Other
Father's Side	❒	❒	❒	❒	❒	❒ _____
Mother's Side	❒	❒	❒	❒	❒	❒ _____

Your oldest grandparent lived to the age of _____. ❒ Living ❒ Deceased

_____ _____

Patient Signature Date

_____ _____

Doctor Signature Date