Health History

Patient Name:____ Date: _______________

Describe Health Concern(s) for appointment today, beginning with highest priority: If no Health Concerns write "Wellness Checkup" (Wellness Care is not covered by insurance companies.)

1. ______________________________ 2. ______________________________
3. ______________________________ 4. ______________________________

Explanation of how Health Concern(s) occurred:

1. ______________________________ 2. ______________________________
3. ______________________________ 4. ______________________________

Health Concern(s) started when: 1: ___/___/____ 2. ___/___/____ 3. ___/___/____ 4. ___/___/____

Your Chiropractic Care will be filed as: Auto Insurance Worker's Compensation Personal Insurance Cash

Frequency of Health Concern: Constant / Daily / Weekly / Monthly For How Long: ____________

Prior Occurrences: Yes / No How many times:_______ Worse in: A.M. / P.M. / Both

What makes it better:_________________________What makes it worse: _________________________

What were/are you doing for the Health Concern: ____

Does Problem Interfere with work: Yes / No Does Problem Affect Sleep: Yes / No Routine: Yes / No

Is Problem Getting Progressively Worse: Yes / No History of Trauma to Area: Yes / No When: _________

Other Health Care Providers seen for this problem: ____

Type of Treatment:_________________________________Results: ____________________

Sleeping habits:____On back,____On side,____Side w/ arm extended,____On stomach

Hours of sleep a day:_________ On a scale 1-10 what level stress do you experience daily? ________

Sleep Problems: Explain ____

Exercise Routine: Explain ____

How many Meals a Day: _____ How Many Servings a Day: Meat: ____ Vegetables: ____ Fruit: _____

Habits: Tobacco # a day: (Cigarettes Chewing tobacco Cigar Pipe) Alcohol # a week: _______
Coffee # a day:_____ Soft Drinks # a day:_____ Tea # a day: _____ Crave Salty Foods: Yes / No
Crave Ice Cream: Yes / No Diet Foods: Yes / No Fast Food # a week: _______
Glasses of water a day?_______Frequent Activities/Hobbies: ______________________________

Female: Last date of Menstrual Cycle_______________Pregnant: NO / YES Due Date: ___________

Past history of family illnesses or diseases:
Relationship:________________ Illness:____________________Age:________ Living / Deceased
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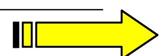
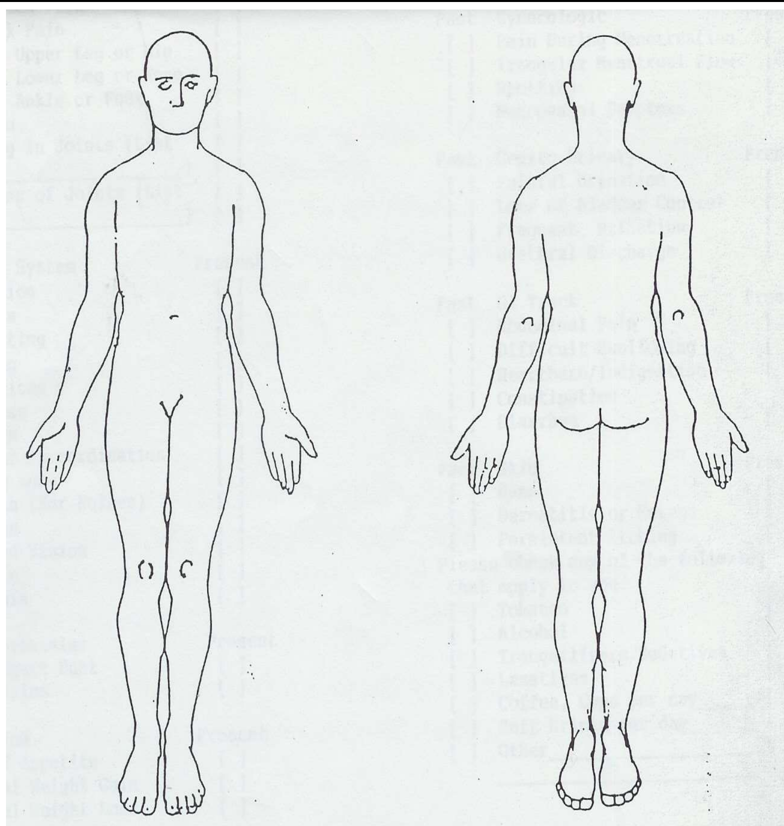


Listed below are common symptoms. If you have ever had a listed symptom in the past or present please check that symptom in the appropriate column.

Past	Musculoskeletal	Present
[ ]	Neck Pain	[ ]
[ ]	Shoulder Pain	[ ]
[ ]	Pain in Upper Arm or Elbow	[ ]
[ ]	Hand Pain	[ ]
[ ]	Upper Back Pain	[ ]
[ ]	Numbness	[ ]
[ ]	Low Back Pain	[ ]
[ ]	Pain in Upper Leg or Hip	[ ]
[ ]	Pain in Lower Leg or Knee	[ ]
[ ]	Pain in Ankle or Foot	[ ]
[ ]	Jaw Pain	[ ]
[ ]	Swelling in Joints	[ ]
	List Joints__________________	
[ ]	Stiffness of Joints	[ ]
	List Joints__________________	
Past	**Nervous System**	**Present**
[ ]	Depression	[ ]
[ ]	Insomnia	[ ]
[ ]	Bed Wetting	[ ]
[ ]	Convulsions	[ ]
[ ]	Dizziness/Fainting	[ ]
[ ]	Headache	[ ]
[ ]	Muscular Incoordination	[ ]
[ ]	Hearing Loss	[ ]
[ ]	Tinnitus (Ear Noises)	[ ]
[ ]	Ear Pain	[ ]
[ ]	Impaired Vision	[ ]
[ ]	Eye Pain	[ ]
[ ]	Paralysis	[ ]

Past	Cardiovascular	Present
[ ]	Rapid Heart Beat	[ ]
[ ]	Slow Heart Beat	[ ]
[ ]	Swelling Ankles	[ ]
[ ]	Poor Circulation	[ ]
[ ]	Low Blood Pressure	[ ]
[ ]	High Blood Pressure	[ ]
[ ]	Chest Pains	[ ]
Past	**Endocrine**	**Present**
[ ]	Loss of Appetite	[ ]
[ ]	Abnormal Weight Gain	[ ]
[ ]	Abnormal Weight Loss	[ ]
Past	**Respiratory**	**Present**
[ ]	Shortness of Breath	[ ]
[ ]	Chronic Cough	[ ]
[ ]	Sinus Infection	[ ]
Past	**Gynecologic**	**Present**
[ ]	Lumps in Breast	[ ]
[ ]	Cramps or back aches	[ ]
[ ]	Irregular Menstrual Flow	[ ]
[ ]	Vaginal Discharge	[ ]
[ ]	Spotting	[ ]
[ ]	Menopausal Symptoms	[ ]
Past	**Genito-Urinary**	**Present**
[ ]	Painful Urination	[ ]
[ ]	Loss of Bladder Control	[ ]
[ ]	Frequent Urination	[ ]
[ ]	Urethral Discharge	[ ]
[ ]	Blood In Urine	[ ]

Past	GI Tract	Present
[ ]	Abdominal Pain	[ ]
[ ]	Difficult Swallowing	[ ]
[ ]	Heartburn/ Indigestion	[ ]
[ ]	Constipation	[ ]
[ ]	Diarrhea	[ ]
[ ]	Liver Trouble	[ ]
[ ]	Laxatives	[ ]
Past	**Skin**	**Present**
[ ]	Rash	[ ]
[ ]	Dermatitis or Eczema	[ ]
[ ]	Persistent Itching	[ ]
Past	**Condition**	**Present**
[ ]	Hemorrhoids	[ ]
[ ]	Emphysema	[ ]
[ ]	Rheumatic Heart Disease	[ ]
[ ]	Arthritis	[ ]
[ ]	Asthma	[ ]
[ ]	Drug or Alcohol Dependency	[ ]
[ ]	Angina	[ ]
[ ]	Diabetes	[ ]
[ ]	Heart Attack	[ ]
[ ]	Ulcer	[ ]
[ ]	Stroke	[ ]
[ ]	Kidney Stones	[ ]
[ ]	Bladder Infection	[ ]
[ ]	Kidney Infection	[ ]
[ ]	Gall Bladder	[ ]
[ ]	Cancer	[ ]
[ ]	Prostate Troubles	[ ]
[ ]	HIV Positive/AIDS	[ ]
[ ]	Other_________________	[ ]



PAIN DRAWING

If you are experiencing pain, accurately mark the location and type of pain on the body to the left. Use the appropriate letter(s), to mark all affected areas.

Stabbing (S) Ache (A) Numbness (N)

Tingling (T) Burning (B)

Please mark on the line the pain level (0-10) that most accurately represents your pain:

Right Now _________

At Best___________

At Worst___________

(Pain Scale)

(NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 (UNBEARABLE PAIN)