

**Personal Health History »**

All information will be kept strictly confidential. Your responses will help determine if chiropractic treatment will benefit you. Unless we sincerely feel that your condition will respond satisfactorily, we will not recommend treatment.

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Today's Date: \_\_\_\_\_

\*Please check the degree of all conditions you currently have or have had. To be responsible for your case, we need your complete health history.

**O = Occasional      F = Frequent      C = Constant**

<p><b>O F C</b></p> <p><b>Muscle / Joint</b></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Arthritis</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bursitis</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Foot trouble</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hernia</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Low back pain</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Lumbago</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Neck pain, stiffness</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Pain between shoulders</p> <p><b>General</b></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Allergy</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Chills</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Convulsions</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Dizziness</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Fainting</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Fatigue</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Fever</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Headache</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Loss of sleep</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Loss of weight</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Nervousness, depression</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Neuralgia</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Numbness</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sweats</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Tremors</p> <p><b>Cardiovascular</b></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hardening of arteries</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> High blood pressure</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Low blood pressure</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Pain over heart</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Poor circulation</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Rapid heartbeat</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Slow heartbeat</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Swelling of ankles</p> <p><b>Genitourinary</b></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bed-wetting</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Blood in urine</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Frequent urination</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Lack of kidney control</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Kidney infection</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Painful urination</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Prostate trouble</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Pus in urine</p>	<p><b>O F C</b></p> <p><b>Eye, Ear, Nose and Throat</b></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Asthma</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Colds</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Crossed eyes</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Deafness</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Dental decay</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Earache</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Ear discharge</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Ear noise</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Enlarged glands</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Enlarged thyroid</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Eye pain</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Failing vision</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Far sightedness</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Gum trouble</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hay fever</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hoarseness</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Nasal obstruction</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Near sightedness</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Nose bleeds</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sinus infection</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sore throat</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Tonsillitis</p> <p><b>Gastrointestinal</b></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Belching or gas</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Colitis</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Colon trouble</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Constipation</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Diarrhea</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Difficult digestion</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bloating abdomen</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Excessive hunger</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Gallbladder trouble</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hemorrhoids</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Intestinal worms</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Jaundice</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Liver trouble</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Nausea</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Pain over stomach</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Poor appetite</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Vomiting</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Vomiting of blood</p>	<p><b>O F C</b></p> <p><b>Skin</b></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Boils</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bruise easily</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Dryness</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hives or allergy</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Itching</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Skin eruptions (rash)</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Varicose veins</p> <p><b>Pain or numbness in</b></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Shoulders</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Arms</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Elbows</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hands</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hips</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Legs</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Knees</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Feet</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Painful tailbone</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Poor posture</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sciatica</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Spinal curvature</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Swollen joints</p> <p><b>Respiratory</b></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Chest pain</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Chronic cough</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Difficult breathing</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Spitting up blood</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Spitting up phlegm</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Wheezing</p> <p><b>Women only</b></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Congested breasts</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Cramps or backache</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Excess menstrual flow</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hot flashes</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Irregular cycle</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Lumps in breast</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Menopause</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Painful menstruation</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Vaginal discharge</p> <p>Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, how many months? _____</p> <p>How many children do you have? _____</p>
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*Check any of the following conditions you currently have or have had:*

Alcoholism

Anemia

Appendicitis

Arteriosclerosis

Cancer

Chicken pox

Cholera

Cold sores

Diabetes

Diphtheria

Eczema

Edema

Emphysema

Epilepsy

Fever blisters

Goiter

Gout

Heart disease

Herpes

Influenza

Lumbago

Malaria

Measles

Miscarriage

Multiple sclerosis

Mumps

Pacemaker

Pleurisy

Pneumonia

Polio

Rheumatic fever

Scarlet fever

Stroke

Tuberculosis

Typhoid fever

Ulcers

Venereal disease

Whooping cough

Describe chiropractic problem: \_\_\_\_\_

How long have you had this condition? \_\_\_\_\_ Is it getting worse?  Yes  No

Does it bother your (check appropriate box):  Work  Sleep  Other (please specify): \_\_\_\_\_

What seemed to be the initial cause: \_\_\_\_\_

Have you seen a chiropractor before?  Yes  No If yes, how long ago? \_\_\_\_\_

For what reason? \_\_\_\_\_

Are you under the care of a physician?  Yes  No If yes, for what reason? \_\_\_\_\_

Have you been hospitalized in the last 5 years?  Yes  No If yes, for major surgery?  Yes  No for serious injury?  Yes  No

Have you had any mental or emotional disorders?  Yes  No If yes, when?

Indicate the drugs do you now take?  Birth control pills  Tranquilizers  Pain Killers  Other (specify):

Do you wear:  heel lifts?  sole lifts?  inner soles?  area supports?  negative heels?  platform shoes?

What is the age of your mattress? Is it  comfortable?  uncomfortable? Do you use a bedboard?  Yes  No

How is most of your day spent?  standing  sitting  walking  other (specify):

Have you ever: Yes No If yes, briefly explain.

- had a broken bone?  Yes  No
- been hospitalized?  Yes  No
- had strains or sprains?  Yes  No
- used a cane, crutch or other support?  Yes  No
- been struck unconscious?  Yes  No
- been hospitalized for other than surgery?  Yes  No

- Do you:
- take minerals, herbs or vitamins?  Yes  No
  - think you need minerals, herbs or vitamins?  Yes  No
  - have any drug allergy?  Yes  No

- When did you last have:
- |                         | Never                    | 0-6 mos.                 | 6-18 mos.                | longer                   |
|-------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| - spinal x-ray?         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| - spinal examination?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| - physical examination? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

HABITS	None	Light	Mod	Heavy
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Soft Drinks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Salty Foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sugar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Sweeteners	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please list any other health conditions you have been treated for, or surgery you have had in the last ten years.

**FAMILY HEALTH HISTORY**

Some health conditions are the result of hereditary spinal weaknesses. Information about your immediate family members, brothers, sisters, parents, and grandparents will give us a better understanding of your total health picture.

RELATIONSHIP	PRESENT AND PAST HEALTH PROBLEMS

