

Confidential Health History

Please fill out this questionnaire completely. Your answers will help us determine if chiropractic care can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. **THANK YOU.**

Name _____ SS# _____ Date _____
 Address _____ City _____ State _____ Zip _____
 Home Phone _____ Work Phone _____ Cell _____ E-mail _____
 Birthday _____ Age _____ M F Marital Status _____ Spouse's Name _____ No. Children _____
 Occupation _____ Is your condition due to an injury at work? Yes No
 Employer's Name _____ Address _____
Who referred you to us? _____ **Who is responsible for paying for your treatment?** _____
 Do you have health insurance? _____ If yes, with which insurance company? _____
 Have you ever had previous chiropractic care? _____ If yes, date of last care: _____
 Name of your medical doctor: _____ Address _____

If we are able to accept your case, what type of care do you want? **Corrective Care** **Pain Relief Only**

Please check the appropriate box for any of the following symptoms which you have experienced. **Only check the box if you have experienced the symptom; otherwise please leave it blank.** We need all the facts about your health history before we accept your case. **THIS INFORMATION IS CONFIDENTIAL**

O – OCCASSIONAL	F – FREQUENT	C – CONSTANT
<p>O F C</p> <p>GENERAL</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"/> Weight loss</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>MUSCLE & JOINT</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 problems</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 or stiffness</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Pain between shoulder blades</p> <p>Pain or numbness in:</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"/> Tail bone</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>O F C</p> <p>GASTRO-INTESTINAL</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"/> Distension of 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"/> Gall bladder 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"/> Stomach pain</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>EYES, EARS, NOSE & THROAT</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"/> 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 noises</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/teeth 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"/> Nosebleeds</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sinus problems</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>O F C</p> <p>CARDIO-VASCULAR</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"/> Chest pain</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 heart beat</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Slow heart beat</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Swelling of ankles</p> <p>RESPIRATORY</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>SKIN</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"/> Dry skin</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/rashes</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Varicose veins</p> <p>GENITO-URINARY</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"/> Inability to control urination</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Kidney infection or stones</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>FOR WOMEN ONLY</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Fibrotic breasts</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Menstrual cramps or backache</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Excessive 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"/> Menopausal symptoms</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Vaginal discharge</p> <p>Are you pregnant? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Last gynecological exam: _____</p>

Please check the following conditions you have had in the past:

<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Cold sores	<input type="checkbox"/> Goiter	<input type="checkbox"/> Miscarriage	<input type="checkbox"/> Scarlet fever
<input type="checkbox"/> Anemia	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Gout	<input type="checkbox"/> Multiple sclerosis	<input type="checkbox"/> Stroke
<input type="checkbox"/> Appendicitis	<input type="checkbox"/> Diphtheria	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Mumps	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Arteriosclerosis	<input type="checkbox"/> Eczema	<input type="checkbox"/> Influenza	<input type="checkbox"/> Pleurisy	<input type="checkbox"/> Typhoid fever
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Low back pain	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Cancer	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Malaria	<input type="checkbox"/> Polio	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Chorea	<input type="checkbox"/> Fever blisters	<input type="checkbox"/> Measles	<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Whooping cough

What health problem do you want us to treat? _____
 How long have you had these symptoms? _____ Have you had similar symptoms in the past? _____
 How did it happen? _____
 What activities make your symptoms worse? _____
 Are your symptoms getting worse? Yes No Are your symptoms: Constant They come and go
 Is this condition interfering with your: Work Sleep Daily routine Family or spouse relationship Other _____

What things can't you do now that you hope to be able to do after your treatments are done?

How long has it been since you really felt good? _____

List previous diagnoses and treatments you have received for your present condition: _____

What do you believe is wrong with you? _____

What other health problems do you have: _____

List any surgeries and dates: _____

Drugs you now take: Nerve pills Pain killers Muscle relaxers Heart pills Tranquilizers Antibiotics Birth control pills Others _____

How often do you go to the dentist? Every six months Yearly Toothache or emergency only

How old is your mattress? _____ Is it Comfortable? Uncomfortable?

Do you wear: Heel lifts? Inner soles? Arch supports?

Have you been in an car crash (even a "fender-bender") in the: Past year Past five years Five to ten years ago Over ten years ago Never

Please describe the crash _____

Have you ever had any mental or emotional disorders? Yes No If so, when? _____ Type _____

Have others in your family had such disorders? Yes No If so, when? _____ Type _____

FAMILY HEALTH INFORMATION (Many health problems are hereditary. Thus, information about your family members will give us a better picture of your total health picture.)

NAME	RELATIONSHIP to YOU	PAST AND PRESENT HEALTH PROBLEMS

HAVE YOU EVER: YES NO Please describe briefly

Been knocked unconscious? _____

Used a cane, crutch, or other support? _____

Been treated for a spine or nerve disorder? _____

Had a fractured bone? _____

Been hospitalized for other than surgery? _____

DO YOU: _____

Now take vitamins or minerals? _____

Think you may need vitamins or minerals? _____

Have an allergy to any drug? _____

DATE OF LAST: Less than 6 months 6-18 months Over 18 months Never

Physical examination

Spinal examination

Blood test

Urine test

Spinal x-ray

Chest x-ray

Dental x-ray

HABITS Heavy Moderate Light None

Alcohol

Coffee

Tobacco

Drugs

Appetite

Sleep

Exercise

List below all conditions for which you have been treated in the past 10 years.

WHO SHOULD WE CONTACT IN CASE OF EMERGENCY? (Name of relative or close friend NOT living with you):

Name _____ Relationship _____

Address _____ Phone _____

City _____ State _____ Zip _____