



**HEALTH HISTORY**

**List present complaints:**

- 1. \_\_\_\_\_ For how long? \_\_\_\_\_
- 2. \_\_\_\_\_ For how long? \_\_\_\_\_
- 3. \_\_\_\_\_ For how long? \_\_\_\_\_

Remarks: \_\_\_\_\_  
\_\_\_\_\_

**List other doctors consulted for this condition(s):**

Name \_\_\_\_\_ Address \_\_\_\_\_  
Diagnosis \_\_\_\_\_  
Treatment \_\_\_\_\_  
Results \_\_\_\_\_

Name \_\_\_\_\_ Address \_\_\_\_\_  
Diagnosis \_\_\_\_\_  
Treatment \_\_\_\_\_  
Results \_\_\_\_\_

**Last visit to a medical doctor and why** \_\_\_/\_\_\_/\_\_\_ \_\_\_\_\_  
\_\_\_\_\_

**What surgeries have you had?**

Type \_\_\_\_\_ When \_\_\_\_\_ Doctor \_\_\_\_\_  
Type \_\_\_\_\_ When \_\_\_\_\_ Doctor \_\_\_\_\_  
Type \_\_\_\_\_ When \_\_\_\_\_ Doctor \_\_\_\_\_

Remarks \_\_\_\_\_  
\_\_\_\_\_

**Any serious accidents or falls?**

- 1. \_\_\_\_\_ When \_\_\_\_\_
- 2. \_\_\_\_\_ When \_\_\_\_\_
- 3. \_\_\_\_\_ When \_\_\_\_\_

Remarks \_\_\_\_\_  
\_\_\_\_\_

## Any broken bones?

1. \_\_\_\_\_ When \_\_\_\_\_

2. \_\_\_\_\_ When \_\_\_\_\_

3. \_\_\_\_\_ When \_\_\_\_\_

Remarks \_\_\_\_\_

## Check any of the following you have or have had in the past five years:

### General Symptoms

- Headache
- Fever
- Chills
- Sweats
- Fainting
- Dizziness
- Convulsions
- Loss of sleep
- Fatigue
- Nervousness
- Loss of weight
- Numbness or pain in arms, hands, or legs

### Eyes, Ears, Nose, Throat

- Failing vision
- Near sightedness
- Crossed eyes
- Eye Pain
- Deafness
- Ear ache
- Ear noises
- Ear discharge
- Nose Bleeds
- Nasal obstruction
- Sore throat
- Hoarseness
- Hay fever
- Asthma
- Dental Decay
- Gum Trouble
- Frequent colds
- Enlarged Thyroid
- Tonsillitis
- Sinus infection
- Nasal drainage
- Enlarged glands

### Skin

- Skin eruptions
- Itching
- Bruises easily

- Dryness
- Boils
- Chills
- Varicose veins
- Sensitive skin
- Hives or allergies

### Respiratory

- Chronic cough
- Spitting up phlegm
- Spitting up blood
- Chest Pain
- Difficult breathing

### Cardio-vascular

- Rapid beating heart
- Slow beating heart
- High Blood pressure
- Low blood pressure
- Pain over Heart
- Previous heart stroke
- Hardening of arteries
- Swelling of ankles
- Poor circulation
- Paralytic stroke

### Muscle and joint

- Stiff neck
- Back ache
- Swollen joints
- Tremors
- Painful tailbone
- Foot trouble
- Pain between shoulders
- Hernia
- Spinal curvature
- Faulty posture

### Genitourinary

- Frequent urination
- Painful urination
- Blood in urine
- Pus in urine

- Kidney infection or stones
- Bed wetting
- Inability to control urine
- Prostrate trouble

### Gastrointestinal

- Poor appetite
- Excessive hunger
- Belching or gas
- Nausea
- Vomiting
- Vomiting of blood
- Pain over stomach
- Distention of abdomen
- Constipation
- Diarrhea
- Colon trouble
- Hemorrhoids
- Intestinal worms
- Liver trouble
- Gall bladder trouble
- Jaundice
- Colitis

### Female

- Painful menstrual periods
- Excessive flow
- Hot flashes
- Irregular cycle
- Cramps or back ache
- Previous miscarriage
- Vaginal discharge
- Congested breast
- Lumps in breast
- Menopausal symptoms

**Are you taking any medications and/or diet supplements?**

What \_\_\_\_\_ Frequency \_\_\_\_\_ Doctor \_\_\_\_\_

Remarks \_\_\_\_\_

**Do you have any medication allergies?**

Medication name \_\_\_\_\_ Reaction \_\_\_\_\_ Onset Date \_\_\_\_\_

Medication name \_\_\_\_\_ Reaction \_\_\_\_\_ Onset Date \_\_\_\_\_

Medication name \_\_\_\_\_ Reaction \_\_\_\_\_ Onset Date \_\_\_\_\_

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**List any conditions you have been or are being treated for (i.e. Pneumonia, Rheumatoid Arthritis, Stroke, Heart Disease, Diabetes etc....)** \_\_\_\_\_

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**Are there any other conditions that you experience that you have not mentioned?**

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*Thank you for taking the time to complete this important form. Your honest answers will better help us determine the best treatment plan for you.*

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the office manager. If discrepancies arise with your insurance company we will certainly help rectify the situation but you are ultimately responsible for any bills.
- I authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.
- I choose to decline receipt of my clinical summary after every visit (These summaries are often blank as a result of the nature and frequency of chiropractic care. )

Patient Signature \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_

Guardian or Spouse's  
Signature Authorizing Care \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_