Health History Form

Patient's Name: _____ **Date:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone #: _____ **Date of Birth:** _____ **Age:** _____ **Gender:** _____

Please mark the intensity of your pain today.

1 – NO PAIN
10 – MOST INTENSE EVER FELT

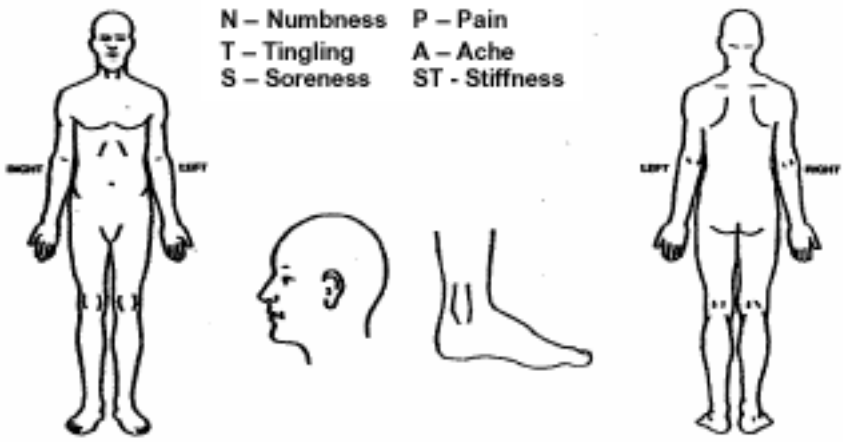
Example Neck 1 2 3 (4) 5 6 7 8 9 10

1. _____ 1 2 3 4 5 6 7 8 9 10
2. _____ 1 2 3 4 5 6 7 8 9 10
3. _____ 1 2 3 4 5 6 7 8 9 10

OFFICE USE ONLY

Please mark area & type of pain on the drawing using the code below.

N – Numbness P – Pain
T – Tingling A – Ache
S – Soreness ST - Stiffness



HABITS

- ❒ Smoking Packs/Day _____
- ❒ Drinking Alcohol _____
- ❒ Coffee Cups/Day _____

EXERCISE

- ❒ None
- ❒ Moderate
- ❒ Daily

Type

FAMILY HISTORY

	Diabetes	Heart	Kidney	Cancer	Back
Mother	❒	❒	❒	❒	❒
Father	❒	❒	❒	❒	❒
Brother, No. of _____	❒	❒	❒	❒	❒
Sister, No. of _____	❒	❒	❒	❒	❒

HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

- ❒ Appendicitis
- ❒ Pneumonia
- ❒ Rheumatic Fever
- ❒ Polio
- ❒ Tuberculosis
- ❒ Whooping Cough
- ❒ Anemia
- ❒ Measles
- ❒ Mumps
- ❒ Chicken Pox
- ❒ Diabetes
- ❒ Cancer
- ❒ Heart Disease
- ❒ Goiter
- ❒ Influenza
- ❒ Pleurisy
- ❒ Alcoholism
- ❒ Venereal Infection
- ❒ Arthritis
- ❒ Epilepsy
- ❒ Mental Disorder
- ❒ Lumbago
- ❒ Eczema
- ❒ HIV Positive

OPERATIONS AND PROCEDURES

DATE(S)		DATE(S)		DATE(S)	
_____	Vaccinations	_____	Tubes in Ears	_____	Sinus
_____	Tonsillectomy	_____	Appendectomy	_____	Hernia
_____	Gall Bladder	_____	Female Organs	_____	Thyroid
_____	Back Operation	_____	Rectal Surgery	_____	Stomach
_____	Other	_____	Other	_____	Other

Health History Form

Do you have any close family history (father/mother, grandparents, aunts/uncles) of any of the following:

❒ Thyroid problems ❒ Diabetes ❒ Gout ❒ Heart conditions ❒ Kidney problems ❒ Ovarian/uterine problems
❒ Liver problems ❒ Gallbladder problems ❒ Stomach problems ❒ Colon problems ❒ Lung conditions ❒ Strokes

Have you had the flu, a cold, or a respiratory illness (cough) in the last 3 weeks? ❒ Yes ❒ No

Do you smoke? ❒ Yes ❒ No When was your last smoke?: _____

Have you experienced a recent trauma (a fall, sports injury, car accident, dental work, surgery, etc.)? ❒ Yes ❒ No
Are you now or have you ever been disabled? ❒ Yes ❒ No When: _____ How:_____

Please answer the following questions in regard to the chief complaints you described on pages 1 and 3.

COMPLAINT

1:	**2:**	**3:**
When and how did this problem begin?		
❒ suddenly ❒ gradually	❒ suddenly ❒ gradually	❒ suddenly ❒ gradually
What makes it better ? / What makes it worse ?		
How would you describe your pain/symptoms ?		
❒ achy ❒ sharp ❒ burning	❒ achy ❒ sharp ❒ burning	❒ achy ❒ sharp ❒ burning
❒ sore ❒ tight & stiff	❒ sore ❒ tight & stiff	❒ sore ❒ tight & stiff
❒ numb ❒ pins & needles	❒ numb ❒ pins & needles	❒ numb ❒ pins & needles
How often do you experience your pain/symptoms ?		
❒ constantly (100%) ❒ frequently (75%)	❒ constantly ❒ frequently	❒ constantly ❒ frequently
❒ intermittently (50%) ❒ occasionally (25%)	❒ intermittently ❒ occasionally	❒ intermittently ❒ occasionally
Does the pain radiate anywhere ?		
❒ down the arms ❒ legs	❒ down the arms ❒ legs	❒ down the arms ❒ legs
Is your complaint affected by the time of day ?		
❒ worse in the morning ❒ evening	❒ worse in morning ❒ evening	❒ worse in morning ❒ evening
❒ better in the morning ❒ evening	❒ better in morning ❒ evening	❒ better in morning ❒ evening
Are you getting: (Circle) worse / better / same	worse / better / same	worse / better / same

Health History Form

GENERAL SYMPTOMS

Never Previously Presently

- ❒ ❒ ❒ Bronchitis
- ❒ ❒ ❒ Chills
- ❒ ❒ ❒ Convulsions
- ❒ ❒ ❒ Dizziness
- ❒ ❒ ❒ Fainting
- ❒ ❒ ❒ Fatigue
- ❒ ❒ ❒ Fever
- ❒ ❒ ❒ Headache
- ❒ ❒ ❒ Loss of sleep
- ❒ ❒ ❒ Loss of weight
- ❒ ❒ ❒ Nervousness
- ❒ ❒ ❒ Neuralgia
- ❒ ❒ ❒ Night sweats
- ❒ ❒ ❒ Numbness/pain in arms/legs/hands
- ❒ ❒ ❒ Wheezing
- ❒ ❒ ❒ Allergy to what: _____

GASTRO-INTESTINAL

Never Previously Presently

- ❒ ❒ ❒ Belching or gas
- ❒ ❒ ❒ Colon trouble
- ❒ ❒ ❒ Constipation
- ❒ ❒ ❒ Diarrhea
- ❒ ❒ ❒ Excessive hunger
- ❒ ❒ ❒ Gall bladder trouble
- ❒ ❒ ❒ Hemorrhoids (Piles)
- ❒ ❒ ❒ Jaundice
- ❒ ❒ ❒ Liver trouble
- ❒ ❒ ❒ Nausea
- ❒ ❒ ❒ Pain over stomach
- ❒ ❒ ❒ Poor appetite
- ❒ ❒ ❒ Poor digestion
- ❒ ❒ ❒ Vomiting
- ❒ ❒ ❒ Vomiting blood

EAR/NOSE/ THROAT

Never Previously Presently

- ❒ ❒ ❒ Asthma
- ❒ ❒ ❒ Crossed Eyes
- ❒ ❒ ❒ Deafness
- ❒ ❒ ❒ Earache
- ❒ ❒ ❒ Ear discharge
- ❒ ❒ ❒ Ear noise
- ❒ ❒ ❒ Enlarged thyroid
- ❒ ❒ ❒ Frequent colds
- ❒ ❒ ❒ Hayfever
- ❒ ❒ ❒ Hoarseness
- ❒ ❒ ❒ Nasal obstruction
- ❒ ❒ ❒ Nose bleeds
- ❒ ❒ ❒ Pain in eyes
- ❒ ❒ ❒ Poor vision
- ❒ ❒ ❒ Sinusitis
- ❒ ❒ ❒ Sore throats
- ❒ ❒ ❒ Tonsilitis

RESPIRATORY

Never Previously Presently

- ❒ ❒ ❒ Chest pain
- ❒ ❒ ❒ Chronic cough
- ❒ ❒ ❒ Difficulty breathing
- ❒ ❒ ❒ Spitting blood
- ❒ ❒ ❒ Spitting phlegm

GENITO-URINARY

- ❒ ❒ ❒ Bed wetting
- ❒ ❒ ❒ Blood in urine
- ❒ ❒ ❒ Frequent urination
- ❒ ❒ ❒ Inability to control urine
- ❒ ❒ ❒ Kidney infection
- ❒ ❒ ❒ Painful urination
- ❒ ❒ ❒ Prostrate trouble

MUSCLES & JOINTS

- ❒ ❒ ❒ Backache
- ❒ ❒ ❒ Foot trouble
- ❒ ❒ ❒ Hernia
- ❒ ❒ ❒ Pain between shoulders
- ❒ ❒ ❒ Painful tailbone
- ❒ ❒ ❒ Stiff neck
- ❒ ❒ ❒ Spinal curvature
- ❒ ❒ ❒ Swollen joints
- ❒ ❒ ❒ Tremors
- ❒ ❒ ❒ Twitching
- ❒ ❒ ❒ Weakness

CARDIO-VASCULAR

- ❒ ❒ ❒ High blood pressure
- ❒ ❒ ❒ Low blood pressure
- ❒ ❒ ❒ Pain over heart
- ❒ ❒ ❒ Poor circulation
- ❒ ❒ ❒ Heart trouble
- ❒ ❒ ❒ Rapid heart
- ❒ ❒ ❒ Slow heart
- ❒ ❒ ❒ Stroke
- ❒ ❒ ❒ Swollen ankles
- ❒ ❒ ❒ Varicose veins

SKIN OR ALLERGIES

- ❒ ❒ ❒ Boils
- ❒ ❒ ❒ Bruise easily
- ❒ ❒ ❒ Dryness
- ❒ ❒ ❒ Eczema
- ❒ ❒ ❒ Hives or allergy
- ❒ ❒ ❒ Itching
- ❒ ❒ ❒ Sensitive skin
- ❒ ❒ ❒ Skin eruptions

FOR WOMEN ONLY

- ❒ ❒ ❒ Cramps or backaches
- ❒ ❒ ❒ Excessive flow
- ❒ ❒ ❒ Hot flashes
- ❒ ❒ ❒ Irregular cycle
- ❒ ❒ ❒ Miscarriage
- ❒ ❒ ❒ Painful periods
- ❒ ❒ ❒ Vaginal discharge
- Y ❒ N ❒ Pregnant at this time?

Date of last papsmear: _____

List any accidents or falls and dates: ❒ Car _____ ❒ Recreation Vehicle _____

❒ Sports _____ ❒ School _____ ❒ Other _____

List any broken bones (fractures) or dislocations: _____

Ever on crutches? ❒ No ❒ Yes Why? _____

Have you ever had any spinal taps or spinal injections? ❒ No ❒ Yes Were you ever knocked unconscious? ❒ No ❒ Yes

Have you ever had a lapse of memory? ❒ No ❒ Yes Have you ever had X-rays taken? ❒ No ❒ Yes When? _____

For what ailments were these X-rays taken? _____

Do you suffer from any condition other than that for which you are now consulting us? _____

Are you currently taking any medication ñ prescription or over-the-counter? ❒ No ❒ Yes What? _____

_____

I have completed this 3-page form to the best of my ability.

Signature: _____ Date: _____