



**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 PRINT**

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 \_\_\_\_\_

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**

- O F C**
- GENERAL**
- Allergy
  - Chills
  - Convulsions
  - Dizziness
  - Fainting
  - Fatigue
  - Fever
  - Headache
  - Loss of sleep
  - Weight loss
  - Nervousness/depression
  - Neuralgia
  - Numbness
  - Sweats
  - Tremors
- MUSCLE & JOINT**
- Arthritis
  - Bursitis
  - Foot problems
  - Hernia
  - Low back pain
  - Lumbago
  - Neck pain or stiffness
  - Pain between shoulder blades
- Pain or numbness in:**
- Shoulders
  - Arms
  - Elbows
  - Hands
  - Hips
  - Legs
  - Knees
  - Feet
  - Tail bone
- Poor posture
  - Sciatica
  - Spinal curvature
  - Swollen joints

- O F C**
- GASTRO-INTESTINAL**
- Belching or gas
  - Colitis
  - Colon trouble
  - Constipation
  - Diarrhea
  - Difficult digestion
  - Distension of abdomen
  - Excessive hunger
  - Gall bladder trouble
  - Hemorrhoids
  - Intestinal worms
  - Jaundice
  - Liver trouble
  - Nausea
  - Stomach pain
  - Poor appetite
  - Vomiting
  - Vomiting of blood
- EYES, EARS, NOSE & THROAT**
- Asthma
  - Colds
  - Deafness
  - Dental decay
  - Earache
  - Ear discharge
  - Ear noises
  - Enlarged glands
  - Enlarged thyroid
  - Eye pain
  - Failing vision
  - Far sightedness
  - Gum/teeth trouble
  - Hay fever
  - Hoarseness
  - Nasal obstruction
  - Near sightedness
  - Nosebleeds
  - Sinus problems
  - Sore throat
  - Tonsillitis

- O F C**
- CARDIO-VASCULAR**
- Hardening of arteries
  - High blood pressure
  - Low blood pressure
  - Chest pain
  - Poor circulation
  - Rapid heart beat
  - Slow heart beat
  - Swelling of ankles
- RESPIRATORY**
- Chest pain
  - Chronic cough
  - Difficult breathing
  - Spitting up blood
  - Spitting up phlegm
  - Wheezing
- SKIN**
- Boils
  - Bruise easily
  - Dry skin
  - Hives or allergy
  - Itching
  - Skin eruptions/rashes
  - Varicose veins
- GENITO-URINARY**
- Bed wetting
  - Blood in urine
  - Frequent urination
  - Inability to control urination
  - Kidney infection or stones
  - Painful urination
  - Prostate trouble
  - Pus in urine
- FOR WOMEN ONLY**
- Fibrotic breasts
  - Menstrual cramps or backache
  - Excessive menstrual flow
  - Hot flashes
  - Irregular cycle
  - Menopausal symptoms
  - Vaginal discharge
- Are you pregnant? Yes  No
- Last gynecological exam: \_\_\_\_\_

**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   |

**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	
Been knocked unconscious?	<input type="checkbox"/>	<input type="checkbox"/>	Please describe briefly _____ _____ _____ _____
Used a cane, crutch, or other support?	<input type="checkbox"/>	<input type="checkbox"/>	
Been treated for a spine or nerve disorder?	<input type="checkbox"/>	<input type="checkbox"/>	
Had a fractured bone?	<input type="checkbox"/>	<input type="checkbox"/>	
Been hospitalized for other than surgery?	<input type="checkbox"/>	<input type="checkbox"/>	

**DO YOU:**

Now take vitamins or minerals?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Think you may need vitamins or minerals?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have an allergy to any drug?	<input type="checkbox"/>	<input type="checkbox"/>	_____

**DATE OF LAST:**

	Less than 6 months	6-18 months	Over 18 months	Never
Physical examination	<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"/>
Blood test	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urine test	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spinal x-ray	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chest x-ray	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dental x-ray	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**HABITS**

	Heavy	Moderate	Light	None
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"/>
Appetite	<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"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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 \_\_\_\_\_