

PERSONAL HEALTH HISTORY

Patient's Name _____ DOB _____ Date _____

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

Describe chiropractic problem: _____

How long have you had this condition?	Is it getting worse? <input type="checkbox"/> Yes <input type="checkbox"/> No
Does it bother your (check appropriate box): <input type="checkbox"/> Work <input type="checkbox"/> Sleep <input type="checkbox"/> Other (please specify)	
What seemed to be the initial cause?	
Have you seen a chiropractor before? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, how long ago? _____	
For what reason?	

