

**PATIENT HEALTH HISTORY - Chiropractic**

Please complete this questionnaire. Your answers will help us determine how Chiropractic can help you.

**NAME** \_\_\_\_\_ **INITIAL VISIT DATE** \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Postal Code \_\_\_\_\_

Home Phone # \_\_\_\_\_  Work Phone # \_\_\_\_\_

E-mail (H) \_\_\_\_\_  E-mail (W) \_\_\_\_\_ Birth Date \_\_\_\_\_  
(DAY/ MONTH/ YEAR)

Sex M / F Height \_\_\_\_\_ Weight \_\_\_\_\_ Family Doctor \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

How did you hear about our clinic?  Y Pgs  Internet  Referral \_\_\_\_\_  Other \_\_\_\_\_

**Have you had** Chiropractic care before?  Yes  No Dr. \_\_\_\_\_ Last Visit: \_\_\_\_\_

Have you ever had "Spinal" X-rays taken?  Yes  No Reason: \_\_\_\_\_ Date: \_\_\_\_\_

Other "Diagnostic Imaging":  MRI  CT  Ultrasound  Other Date: \_\_\_\_\_ Location: \_\_\_\_\_

Please circle  present conditions and check (✓) previous conditions.

**GENERAL SYMPTOMS**

HEADACHES  
MIGRAINES  
FEVER  
CHILLS  
SWEATS  
FAINTING  
DIZZINESS  
SEIZURES  
CONVULSIONS  
LOSS OF SLEEP  
FATIGUE  
NERVOUSNESS  
LOSS OF WEIGHT  
NUMBNESS OR TINGLING IN  
ARMS, LEGS OR HANDS  
ALLERGIES  
WHEEZING  
**E.E.N.T.**  
FAILING VISION  
NEAR SIGHTED  
FAR SIGHTED  
EYE PAIN  
HEARING LOSS  
EARACHE  
RINGING IN EARS  
NOSEBLEEDS

SORE THROAT  
HOARSENESS  
ASTHMA  
CHRONIC COUGH  
FREQUENT COLDS  
ENLARGED THYROID  
TONSILITIS  
SINUS INFECTION  
ENLARGED GLANDS  
**SKIN**  
ITCHING  
RASHES  
BRUISING EASILY  
VARICOSE VEINS  
SENSITIVE SKIN  
HIVES  
**RESPIRATORY**  
CHRONIC COUGH  
SPITTING UP PHLEGM  
CHEST PAIN WITH  
BREATHING  
DIFFICULT BREATHING  
**CARDIOVASCULAR**  
RAPID HEART BEAT  
SLOW HEART BEAT  
HIGH BLOOD PRESSURE

LOW BLOOD PRESSURE  
CHEST PAIN ON ACTIVITY  
PREVIOUS STROKE  
HARDENING OF ARTERIES  
SWOLLEN ANKLES  
POOR CIRCULATION  
**MUSCLE & JOINT**  
NECK ACHE  
BACKACHE  
SWOLLEN JOINTS  
PAINFUL TAILBONE  
FOOT PAIN  
SHOULDER PAIN  
KNEE PAIN  
HERNIA  
SPINAL CURVATURE  
FAULTY POSTURE  
ARTHRITIS  
**GENITOURINARY**  
FREQUENT URINATION  
PAINFUL URINATION  
BLOOD IN URINE  
KIDNEY INFECTION  
KIDNEY STONES  
BED WETTING  
BLADDER INCONTINANCE

PROSTATE TROUBLE  
**GASTROINTESTINAL**  
POOR APPETITE  
DIFFICULT DIGESTION  
EXCESSIVE HUNGER  
BELCHING  
HEARTBURN  
NAUSEA  
VOMITING  
STOMACH PAIN  
CONSTIPATION  
DIARRHEA  
FLATULENCE  
HEMORRHOIDS  
LIVER TROUBLE  
GALL BLADDER TROUBLE  
JAUNDICE  
COLITIS  
**WOMEN ONLY**  
PAINFUL MENSTRUATION  
EXCESSIVE FLOW  
HOT FLASHES  
IRREGULAR CYCLE  
CRAMPS OR BACKACHE  
CONGESTED BREAST  
LUMPS IN BREAST

**Have you ever had any of the following diseases/conditions?**

HYPERTENSION	MUMPS	EPILEPSY	CHICKEN POX	DIPHTHERIA	OSTEOARTHRITIS
HEART DISEASE	MEASLES	DIABETES	SHINGLES	POLIO	RHEUMATOID ARTHRITIS
LUNG DISEASE	RUBELLA	ANEMIA	MONONUCLEOSIS	INFLUENZA	GOUT
CANCER	MALARIA	HYPERTHYROIDISM	VENEREAL DISEASE	SCARLET FEVER	PSORIASIS
STROKE	TUBERCULOSIS	HYPOTHYROIDISM	ALCOHOLISM	RHEUMATIC FEVER	SCOLIOSIS

Other (specify): \_\_\_\_\_

**Has anyone in your family had any of the following conditions/diseases?**

HYPERTENSION	DIABETES	SCOLIOSIS	LOW BACK PAIN
HEART DISEASE	TUBERCULOSIS	RHEUMATOID ARTHRITIS	DISC DISEASE
LUNG DISEASE	MULTIPLE SCLEROSIS	ANKYLOSING SPONDYLITIS	SPINAL SURGERY
STROKE	ALZHEIMERS DISEASE	OSTEOARTHRITIS	MIGRAINE HEADACHES
CANCER	GOUT	OSTEOPOROSIS	EPILEPSY

Other (specify): \_\_\_\_\_

**Smoking:**  Yes  No How long? \_\_\_\_\_ **Pregnancy:**  Yes  No How many weeks? \_\_\_\_\_

**Medications/Supplements you currently take:** \_\_\_\_\_

**Surgeries you have had in the past:** \_\_\_\_\_