



HEALTH HISTORY FORM

Patients 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

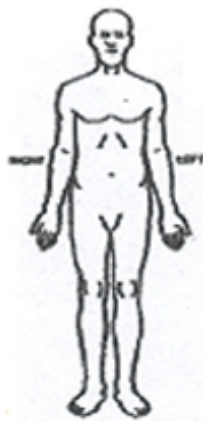
1 2 3 4 5 6 7 8 9 10

1 2 3 4 5 6 7 8 9 10

1 2 3 4 5 6 7 8 9 10

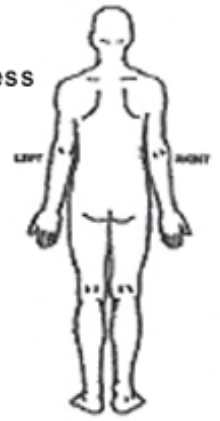
1 2 3 4 5 6 7 8 9 10

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



N - Numbness
T - Tingling
S - Soreness

P - Pain
A - Ache
ST - Stiffness



HABITS

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

EXERCISE

- None
- Moderate
- Daily
- Type _____

FAMILY HISTORY

- | | | | | | |
|-----------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| | Diabetes | Heart | Kidney | Cancer | Back |
| Mother | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Father | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Brother, No. of _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sister, No. of _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

- | | | | |
|--|--------------------------------------|---|--|
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Measles | <input type="checkbox"/> Goiter | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Mumps | <input type="checkbox"/> Influenza | <input type="checkbox"/> Mental Disorder |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Lumbago |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Cancer | <input type="checkbox"/> Venereal Infection | <input type="checkbox"/> HIV Positive |

OPERATIONS AND PROCEDURES

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

Never Previously Presently
GENERAL SYMPTOMS

- 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: _____

Never Previously Presently
GASTRO-INTESTINAL

- 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

Never Previously Presently
EAR/NOSE/THROAT

- 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
- Tonsillitis

Never Previously Presently
RESPIRATORY

- 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
- Prostate 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 backache
- 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 _____ Recreational 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 – prescription – or over-the-counter? No Yes What? _____

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

Signature: _____ Date: _____