Valley Spinal Care

Health History

PATIENT NAME _____ **DATE** _____

Please mark the "Present" column for all health complaints or concerns that you have at this time, the "Past" column for any conditions that you have previously had, and the "Family" column for any chronic or significant conditions that an immediate family member has had at any time.

Past	Present	Family		Please Explain….
☐	☐	☐	Headache	
☐	☐	☐	Neck Pain	
☐	☐	☐	Jaw Pain	
☐	☐	☐	Neck Stiffness	
☐	☐	☐	Neck Motion Restriction	
☐	☐	☐	Loss of Balance	
☐	☐	☐	Loss of Smell	
☐	☐	☐	Loss of Taste	
☐	☐	☐	Loss of Concentration	
☐	☐	☐	Vision Problems	
☐	☐	☐	Sinus Trouble	
☐	☐	☐	Hearing Loss	
☐	☐	☐	Memory Loss	
☐	☐	☐	Heavy Feeling of Head	
☐	☐	☐	Eyes Sensitive to Light	
☐	☐	☐	Pain Behind Eyes	
☐	☐	☐	Persistent Cough	
☐	☐	☐	Upper Back Pain/Stiffness	
☐	☐	☐	Mid Back Pain/Stiffness	
☐	☐	☐	Low Back Pain/Stiffness	
☐	☐	☐	Joint Swelling/Stiffness	
☐	☐	☐	Coordination Problems	
☐	☐	☐	Chest Pain	
☐	☐	☐	Palpitations	
☐	☐	☐	Angina/Heart Attack	
☐	☐	☐	Aneurysm	
☐	☐	☐	Blood Disorder	
☐	☐	☐	High Blood Pressure	
☐	☐	☐	Dermatitis/Eczema/Rash	
☐	☐	☐	Mental Illness	
☐	☐	☐	Excess Perspiration	
☐	☐	☐	Excessive Thirst	
☐	☐	☐	Loss of consciousness	
☐	☐	☐	Shortness of Breath	
☐	☐	☐	Tuberculosis	
☐	☐	☐	Stroke	
☐	☐	☐	Migraines	
☐	☐	☐	HIV (AIDS)	
☐	☐	☐	Lupus	
☐	☐	☐	Hepatitis	
☐	☐	☐	Gout	
☐	☐	☐	Epilepsy	
☐	☐	☐	Emphysema	
☐	☐	☐	Drug/Alcohol Dependence	
☐	☐	☐	Diabetes	
☐	☐	☐	Cancer	
☐	☐	☐	Asthma	
☐	☐	☐	Arthritis	
☐	☐	☐	Anorexia	
☐	☐	☐	Fatigue	
☐	☐	☐	Fainting	
☐	☐	☐	Convulsions	

Past	Present	Family		Please Explain….
☐	☐	☐	Pins & Needles Feelings	
☐	☐	☐	Tingling Sensations	
☐	☐	☐	Shoulder Pain	
☐	☐	☐	Arm or Hand Pain	
☐	☐	☐	Leg or Foot Pain	
☐	☐	☐	Varicose Veins	
☐	☐	☐	Dental Problems	
☐	☐	☐	Difficulty Swallowing	
☐	☐	☐	Abnormal weight gain/loss	
☐	☐	☐	Loss of Appetite	
☐	☐	☐	Indigestion/Heartburn	
☐	☐	☐	Nausea	
☐	☐	☐	Vomiting	
☐	☐	☐	Abdominal Pain	
☐	☐	☐	Gallstones	
☐	☐	☐	Liver Disorder	
☐	☐	☐	Flatulence (Gas)	
☐	☐	☐	Ulcer	
☐	☐	☐	Colitis	
☐	☐	☐	Diarrhea	
☐	☐	☐	Constipation	
☐	☐	☐	Frequent Urination	
☐	☐	☐	Painful Urination	
☐	☐	☐	Loss of Bladder Control	
☐	☐	☐	Kidney Stones	
☐	☐	☐	Kidney Disorder	
☐	☐	☐	Kidney Infection	
☐	☐	☐	Prostate Problems	
☐	☐	☐	Alzheimer's	
☐	☐	☐	Allergies	
☐	☐	☐	Numbness	
☐	☐	☐	Nervousness	
☐	☐	☐	Insomnia	
☐	☐	☐	Ringing in Ears	
☐	☐	☐	Dizziness	
☐	☐	☐	Anemia	
☐	☐	☐	Depression	
☐	☐	☐	Anxiety	
☐	☐	☐	Irritability	
☐	☐	☐	Cold Hands	
☐	☐	☐	Cold Feet	
☐	☐	☐	Flushed Face	
☐	☐	☐	Night Sweats	
☐	☐	☐	Other (Please Explain)	
☐	☐		Accidents	
☐	☐		Activity Limitations	
Other Chiropractors?				

EXERCISE: HOW OFTEN DO YOU EXERCISE?

☐ Daily
☐ A few times a week
☐ A few times a month
☐ Occasionally
☐ Never

Is your exercise:

☐ Strenuous ☐ Moderate ☐ Light

Does it affect your condition?

Yes ☐ ☐ No

HABITS:

	Heavy	Moderate	Light	None	Comments
Alcohol	☐	☐	☐	☐	
Coffee	☐	☐	☐	☐	
Caffeinated Soda	☐	☐	☐	☐	
Drug Use	☐	☐	☐	☐	
Sleep	☐	☐	☐	☐	
Tobacco	☐	☐	☐	☐	

AGE OF YOUR MATTRESS: _____ **COMFORTABLE?** YES NO