

## **Health History**

Patient Name	DATE	
ass mark the "Procent" column for all health complete	into ar concerns that you have at this time, the "Boot" column	

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		mily	Please Explain	
			Headache	
			Neck Pain	
H			Jaw Pain	<del></del>
			Neck Stiffness	<del></del>
			Neck Motion Restriction	<del></del>
			Loss of Balance	<del></del>
$\Box$			Loss of Smell	<del></del>
			Loss of Taste	<del></del>
			Loss of Concentration	<del></del>
			Vision Problems	<del></del>
			Sinus Trouble	<del></del>
			Hearing Loss	<del></del>
			Memory Loss	<del></del>
			Heavy Feeling of Head	<del></del>
			Eyes Sensitive to Light	<del></del>
			Pain Behind Eyes	<del></del>
			Persistent Cough	<del></del>
			Upper Back Pain/Stiffness	<del></del>
			Mid Back Pain/Stiffness	<del></del>
			Low Back Pain/Stiffness	<del></del>
			Joint Swelling/Stiffness	<del></del>
			Coordination Problems	<del></del>
			Chest Pain	<del></del>
			Palpitations	<del></del>
			Angina/Heart Attack	<del></del>
_			Aneurysm	
			Blood Disorder	
			High Blood Pressure	
П			Dermatitis/Eczema/Rash	
_			Mental Illness	
			Excess Perspiration	
			Excessive Thirst	
			Loss of consciousness	
			Shortness of Breath	
			Tuberculosis	
			Stroke	
			Migraines	
			HIV (AIDS)	
			Lupus	
			Hepatitis	<del></del>
			Gout	<del></del>
			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			
☐ ☐ ☐ Abnormal weight gain/loss☐ ☐ ☐ Loss of Appetite			
□ □ Indigestion/Heartburn			
□ □ □ Nausea			
☐ ☐ ☐ Vomiting☐ ☐ Abdominal Pain	<del></del>		
Gallstones			
□ □ Liver Disorder			
□ □ □ Flatulence (Gas)			
Ulcer Colitis			
☐ ☐ ☐ Collus			
□ □ □ Constipation			
□ □ □ Frequent Urination	<del></del>		
□ □ □ Painful Urination			
□ □ □ Loss of Bladder Control □ □ □ Kidney Stones			
□ □ Kidney Disorder			
□ □ Kidney Infection			
□ □ □ Prostate Problems □ □ □ Alzheimer's			
│ □ □ □ 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?			
	HABITS: Heavy Moderate Light None Comments		
☐ Daily☐ A few times a week	Alcohol		
☐ A few times a week	Coffee		
☐ Occasionally	Caffeinated Soda		
□ Never	Sleep		
Is your exercise:	Tobacco		
☐ Strenuous ☐ Moderate ☐ Light			
Yes   No	AGE OF YOUR MATTRESS: COMFORTABLE? YES NO		
169 - 110	-		