



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

