

PATIENT HEALTH HISTORY

Patient name (please print): _____

PLEASE CHECK THE FOLLOWING CONDITIONS YOU HAVE OR HAVE HAD AND HOW OFTEN IT OCCURRED:

OCCASIONAL	FREQUENT	CONSTANT	MUSCLE & JOINT
			Arthritis
			Bursitis
			Carpal tunnel
			Foot trouble
			Hernia
			Low back pain
			Neck pain or stiffness
			Pain between shoulders
			Pain or numbness in:
			Shoulders
			Arms
			Elbows
			Hands
			Hips
			Legs
			Knees
			Feet
			Tail bone
			Poor posture
			Sciatica
			Spinal curvature (scoliosis)
			Swollen joints

OCCASIONAL	FREQUENT	CONSTANT	GENERAL
			Allergy
			Chills
			Convulsions
			Dizziness
			Fainting
			Fatigue
			Fever
			Headache
			Loss of sleep
			Nervousness/depression
			Neuralgia (nerve pain)
			Numbness
			Sweats
			Tremors
			Weight loss

OCCASIONAL	FREQUENT	CONSTANT	WOMEN
			Congested breasts
			Cramps or backache
			Excessive menstrual flow
			Hot flashes
			Irregular cycle
			Menopausal symptoms
			Painful menstruation
			Vaginal discharge
			Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No

OCCASIONAL	FREQUENT	CONSTANT	EYES, EARS, NOSE, & THROAT
			Asthma
			Colds
			Crossed eyes
			Deafness
			Dental decay
			Earache
			Ear discharge
			Ear noises
			Enlarged glands
			Enlarged thyroid
			Eye pain
			Failing vision
			Farsighted
			Gum trouble
			Hay fever
			Hoarseness
			Nasal obstruction
			Nearsighted
			Nose bleeds
			Sinus infection
			Sore throat
			Tonsillitis

OCCASIONAL	FREQUENT	CONSTANT	GASTROINTESTINAL
			Belching or gas
			Colitis
			Colon trouble
			Constipation
			Diarrhea
			Difficult digestion
			Distension of abdomen
			Excessive hunger
			Gall bladder trouble
			Hemorrhoids
			Intestinal worms
			Jaundice
			Liver trouble
			Nausea
			Pain over stomach
			Poor appetite
			Vomiting
			Vomiting of blood

OCCASIONAL	FREQUENT	CONSTANT	CARDIOVASCULAR
			Hardening of arteries
			High blood pressure
			Low blood pressure
			Pain over heart
			Poor circulation
			Rapid heart beat
			Slow heart beat
			Swelling of ankles

PATIENT HEALTH HISTORY *(continued)*

DO YOU:

Now take vitamins or minerals? Yes No Describe: _____
 Think you may need vitamins or minerals? Yes No Describe: _____
 Have an allergy to any drug? Yes No Describe: _____

APPROXIMATE DATE OF LAST:	Less than 6 months	6–18 months	Over 18 months	Never
Spinal examination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical examination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood test	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chest x-ray	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spinal x-ray	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dental x-ray	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urine test	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

List below all conditions for which you have been treated in the past 10 years:

HABITS:	Heavy	Moderate	Light	None
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

FAMILY HEALTH INFORMATION – Many health problems are the result of hereditary spinal weakness; therefore, information about your family members will give the doctor a better understanding of your current health status.

Relation: _____ Past health problems: _____ Present health problems: _____
 Relation: _____ Past health problems: _____ Present health problems: _____
 Relation: _____ Past health problems: _____ Present health problems: _____

 Signature of patient, parent, or legal representative/guardian

 Date

 Printed name of patient, parent, or legal representative/guardian

 Relationship to patient