

# Health History

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email: \_\_\_\_\_ Occupation: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Married Single Divorced Widowed

Kids Names: \_\_\_\_\_

Referred By: \_\_\_\_\_

## **Childhood History: Circle all that apply**

Did you have any childhood illnesses?	Yes	No
Did you have any serious falls as a child?	Yes	No
Did you play youth sports?	Yes	No
Did you take Medications?	Yes	No
Did you have surgery?	Yes	No
Have you fallen / jumped from a height over three feet?	Yes	No
Were you in any car accidents as a child?	Yes	No
Was there any prolonged use of medicine such as antibiotics or an inhaler?	Yes	No
Did you suffer any other traumas (physical or emotional)	Yes	No
As a child, were you under regular chiropractic care?	Yes	No

## **Please share any additional information:**

\_\_\_\_\_  
\_\_\_\_\_

## **Adult – (18 to present)**

Do/did you smoke?	Yes	No	<b><u>Rate these following as Poor, Good, Excellent:</u></b>
Do/did you drink alcohol?	Yes	No	Diet: _____ What do you eat? _____
Have you been in any accidents?	Yes	No	Exercise: _____ When and what? _____
Have you had any surgery?	Yes	No	Sleep: _____ Hours per day?

\_\_\_\_\_  
\_\_\_\_\_ General Health: \_\_\_\_\_

## **Please list ALL medications:**

\_\_\_\_\_  
\_\_\_\_\_

On a scale of 1 – 10 describe your stress level (1=none, 10=extreme):

Occupational: \_\_\_\_\_ Personal: \_\_\_\_\_

**Addressing issues that may have brought you to our office**

If you have no symptoms or complaints, and are here for wellness services, please check here: \_\_\_\_\_ and then skip to Family Health Profile. Otherwise please briefly explain what brought you to our office today:

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**Does this interfere with:** \_\_\_Work \_\_\_Sleep \_\_\_Walking \_\_\_Hobbies \_\_\_Leisure \_\_\_Other

**Have you seen anyone else for this issue?** \_\_\_yes \_\_\_no If yes, who? \_\_\_\_\_

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**Please check (✓) all symptoms you have, even if they do not seem related to your current problem:**

- |   |   |  |  |
|---|---|--|--|
| <input type="checkbox"/> Headaches                | <input type="checkbox"/> Pins and needles in legs | <input type="checkbox"/> Fainting            | <input type="checkbox"/> Neck pain       |
| <input type="checkbox"/> Pins and needles in arms | <input type="checkbox"/> Loss of smell            | <input type="checkbox"/> Back Pain           | <input type="checkbox"/> Loss of balance |
| <input type="checkbox"/> Dizziness                | <input type="checkbox"/> Buzzing in ears          | <input type="checkbox"/> Ringing in ears     | <input type="checkbox"/> Nervousness     |
| <input type="checkbox"/> Numbness in fingers      | <input type="checkbox"/> Numbness in toes         | <input type="checkbox"/> Loss of taste       | <input type="checkbox"/> Stomach Upset   |
| <input type="checkbox"/> Fatigue                  | <input type="checkbox"/> Depression               | <input type="checkbox"/> Irritability        | <input type="checkbox"/> Tension         |
| <input type="checkbox"/> Sleep problems           | <input type="checkbox"/> Stiff Neck               | <input type="checkbox"/> Cold Hands          | <input type="checkbox"/> Cold Feet       |
| <input type="checkbox"/> Diarrhea                 | <input type="checkbox"/> Constipation             | <input type="checkbox"/> Fever               | <input type="checkbox"/> Hot Flashes     |
| <input type="checkbox"/> Cold Sweats              | <input type="checkbox"/> Lights bother eyes       | <input type="checkbox"/> Urinary Problem     | <input type="checkbox"/> Heartburn       |
| <input type="checkbox"/> Mood Swings              | <input type="checkbox"/> Menstrual Pain           | <input type="checkbox"/> Menses Irregularity | <input type="checkbox"/> Ulcers          |

**Family Health Profile:**

At our office we are not only interested in your health and wellbeing but also that of your family and loved ones. Please mention below any health conditions or concerns you may have about your:

Children: \_\_\_\_\_

Spouse: \_\_\_\_\_

Mother: \_\_\_\_\_

Father: \_\_\_\_\_

Brother(s): \_\_\_\_\_

Sister (s): \_\_\_\_\_

Others: \_\_\_\_\_

**Do you:**

- |   |     |                      |
|---|-----|----------------------|
| <b>Drink Bottled water?</b>                       | Yes | No                   |
| <b>Belong to health club?</b>                     | Yes | No                   |
| <b>Use vitamins?</b>                              | Yes | No                   |
| <b>Watch more than 5 hours of TV a week?</b>      | Yes | No                   |
| <b>Spend 1 or more hours on a computer daily?</b> | Yes | No                   |
| <b>Drink Soda?</b>                                | Yes | No (Diet or Regular) |

**What do you do for stress relief?**

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**How many times a week do you exercise?** \_\_\_\_\_

**Are there any other health habits that you could share with us?**

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**Please mark an “X” where you believe your health is and an “O” where you would like to be.**



I consent to a professional and complete chiropractic examination and to any radiographic examination that the doctor deems necessary. I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

Signature \_\_\_\_\_ Date: \_\_\_\_\_