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## PATIENT HEALTH HISTORY

Patient Name _____ Date _____

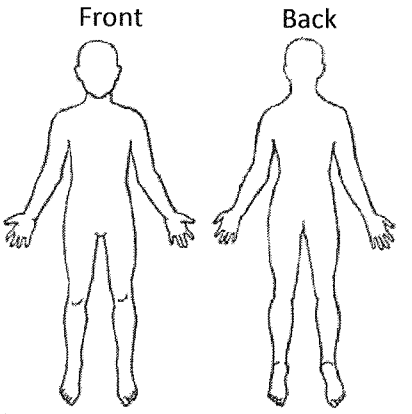
**Describe the reason for your visit:** _____

_____

**Which of the following symptoms are you experiencing:**

- ☐ aching pain
- ☐ shooting pain
- ☐ numbness
- ☐ tingling
- ☐ weakness
- ☐ stiffness
- ☐ throbbing
- ☐ swelling
- ☐ burning
- ☐ cramping
- ☐ other:_____

Mark an X in the area (s) where you experience your symptoms:




**When did your symptoms first appear?** _____

**Are they constant or do they come and go?**_____**Are they getting progressively worse?** _____

**What makes them better?**_____

**What makes them worse?** _____

**Rate the severity of your symptoms from 0 (no pain) to 10 (most severe pain imaginable):** _____

**Does this interfere with** ☐ **work** ☐ **sleep** ☐ **daily activity:**_____ ☐ **other:**_____

**What treatment have you received for this condition?** _____

**Name and contact information of other doctor(s) who have treated you for this condition?** _____

_____

**Have you seen a chiropractor before?** _____**Who?**_____**When?**_____

**For what reason?** _____

**Were you happy with your care?** _____**Why/ Why not?**_____

**Date of last: Physical Exam:** _____ **Spinal Exam:** _____ **Spinal/Other X-Ray:** _____

**MRI,CT, Bone Scan, Ultrasound:** _____ **Blood Test:** _____ **Urine Test:** _____

**Height:** _____ **Weight:** _____ **Weight one year ago:** _____

**When during the day is your energy and alertness best?** _____ **Worst?** _____ **Hours of Sleep at night?** _____

**List any known diet restrictions:** _____

**Do you have any current dietary concerns?** _____ **Any bowel or bladder concerns?** _____

**When was the first date of your last menstrual period?** _____ **Do you have regular menses?** _____

**Are you pregnant?** ☐ **Yes** ☐ **No, Due Date:** _____

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## REVIEW OF SYSTEMS

Patient Name _____ Date _____

**Please circle any symptoms you currently have and *UNDERLINE* any symptoms you have had in the past.**

### GENERAL
Allergies
Chills
Night sweats
Convulsions/Tremors
Dizziness/ Vertigo
Fainting
Memory loss
Fatigue
Fever
Headache
Loss of Sleep
Weight Loss
Weight Gain
Nervousness/Anxiety
Depression
Neuralgia
Numbness
Hair loss
Osteoporosis
Cancer
Diabetes

### SKIN
Bruise easily
Dry skin
Itching
Rash
Varicose veins
Eczema
Chicken pox
Cold sores
Moles

### CARDIOVASCULAR
High Blood Pressure
Low Blood Pressure
High cholesterol
Chest pain
Poor circulation
Irregular heart beat
Ankle swelling/ Edema
Anemia
Arteriosclerosis
Heart Disease
Pacemaker
Stroke

### MUSCLE/JOINT
Spinal Curvature
Facial pain
Neck pain
Neck stiffness
Pain between shoulders
Shoulder pain
Arm pain
Wrist/hand pain
Low back pain
Tailbone pain
Sciatica
Hip pain
Knee pain
Foot pain
Arthritis
Bursitis
Hernia
Poor posture
Swollen joints

### GASTROINTESTINAL
Belching
Gas
Vomiting
Vomiting blood
Constipation
Diarrhea
Difficult digestion
Painful stools
Hemorrhoids
Intestinal parasite
Pain over stomach area
Nausea
Abdominal bloating
Excessive hunger
Loss of appetite
Eating disorder
Gallbladder trouble
Jaundice
Liver trouble
Alcoholism
Appendicitis
Ulcer

### GENITOURINARY
Frequent urination
Lack of bladder control
Painful urination
Blood/ pus in urine
Kidney infection
Prostate trouble
Venereal Infection
Sexual dysfunction

### EENT
Blurred vision
Eye pain/strain
Far/ near sightedness
Glaucoma
Light sensitivity
Hearing impaired
Earache
Ear discharge
Ringing in ears
Sinus infection
Nose bleeds
Colds
Dental/gum decay
Swollen glands
Thyroid trouble
Hoarseness
Difficulty swallowing
Teeth grinding
Jaw pain
Sore throat
Tonsillectomy

### RESPIRATORY
Chronic cough
Difficulty breathing
Asthma
Spitting up blood
Emphysema
Bronchitis
Pneumonia
Tuberculosis

### WOMEN ONLY
PMS
Breast pain/ tenderness
Lumps in breast
Cramps
Backache
Heavy menstrual flow
Light menstrual flow
Irregular cycle
Painful menses
Vaginal discharge
Menopause
Hot flashes
Endometriosis
Ovarian cyst
Uterine fibroids
Abnormal PAP

Are you pregnant? Y N
How many months? ___
Due date: _____

No. of pregnancies: ___
No. of live births: _____

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Patient Name _____ Date _____

| Describe the type and amount of exercise you get: | Describe how you spend most of your time at work:<br><br>Interests/Hobbies: | Habits:<br>☐ Smoking Packs/Day _____<br>☐ Alcohol Drinks/Week _____<br>☐ Coffee Cups/Day _____<br>☐ Stress Reason _____<br>_____ |
|---|---|---|

| MEDICATIONS/CONTRACEPTIVE (current and any you took for an extended period of time): | ALLERGIES: | VITAMINS/HERBS/SUPPLEMENTS: |
|---|---|---|

| List any past trauma (and the approximate date they occurred): | List any past surgeries/ hospitalizations: | List any major past illnesses: |
|---|---|---|

**Family History: Do you have a family history of any of the following diseases or conditions? When answering, include your parents, brother/sisters, and grandparents, if known. Check all that apply.**

☐ Anemia ☐ Cancer ☐ Heart Disease ☐ Mental Illness ☐ Alzheimer's ☐ Arthritis

☐ Diabetes ☐ Hypertension ☐ Multiple Sclerosis ☐ Kidney Disease ☐ Parkinson's ☐ Stroke

☐ Asthma ☐ Epilepsy ☐ Other: _____