# CONFIDENTIAL HEALTH HISTORY

**Name:** _____ **SSN:** _____ **Age:** _____

**Email:** _____ **I would like to receive email reminders** ☐ **Yes** ☐ **No**

**Address:** _____ ☐ **M** ☐ **F** **Date of Birth** _____

**City:** _____ **State:** _____ **Zip:** _____ **Occupation:** _____

**Home Phone:** _____ **Cell Phone:** _____ **Employer:** _____

**Work Phone:** _____ **How did you hear about us?** _____

**Emergency Contact Name:** _____ **Home Phone:** _____

**Is your visit due to an auto or work related injury** ☐ **Yes** ☐ **No**

**List Authorized person(s) for medical release** _____

## CONFIDENTIAL HEALTH HISTORY

**Primary reason for seeking care?** _____

**Problem started on:** _____ **Most recent aggravation** _____

**What makes it worse?** _____

**What makes it better?** _____

**Quality of symptoms:**
☐ **Aching** ☐ **Burning** ☐ **Numbness/Stabbing** ☐ **Dull** ☐ **Deep** ☐ **Superficial**

**If symptoms radiate to other areas, where?**

**Mark Symptoms**
☐**No pain** ☐**1** ☐**2** ☐**3** ☐**4** ☐**5** ☐**6** ☐**7** ☐**8** ☐**9** ☐**10** ☐**Incapacitating pain**

**How frequent is it?**
☐ **Constant (100%)** ☐ **Frequent (75%)** ☐ **Intermittent (50%)** ☐ **Occasional (25%)**

**How long does it last?**
☐ **24hrs/day** (wakes you at night) ☐**16hrs/day** (doesn't wake you) **Other** _____**hrs/day**

**HT:** _____ **in.** **WT:** _____ **lbs** **Hobbies/Sports:** _____

**Have you ever had a concussion? Yes / No**

## DOCTORS NOTES ONLY

| | | | |
|---|---|---|---|
| Daily: | _____ | Initial: | _____ |
| 4xs: | _____ | Cerv: | _____ |
| 3xs: | _____ | Thor: | _____ |
| 2xs: | _____ | Lum: | _____ |
| 1x: | _____ | Adj: | _____ |
| E-O: | _____ | Fup: | _____ |
| Mth: | _____ | FupXr: | _____ |
| | | Tranx: | _____ |
| | | Exer: | _____ |
| | | Extrm: | _____ |

Other Doctors used for Healthcare: _____

Previous Chiropractors: _____

List Supplements or Vitamins you take: _____

List Surgeries/Hospitalizations & dates: _____

List medical procedures & dates: _____

List all Motor Vehicle accidents & dates: _____

**Please check accompanying box if relevant to your health history:**

**General:**
- ☐ Unexplained weight loss/gain
- ☐ Fever/chills
- ☐ Recent trauma
- ☐ Fatigue
- ☐ Trouble sleeping/sleep disorder
- ☐ Past trauma

**Skin:**
- ☐ Rashes
- ☐ Itching
- ☐ Color change
- ☐ New/change in mole
- ☐ Fatigue
- ☐ Trouble sleeping/sleep disorder
- ☐ Past trauma

**Head/Eyes/Ears/Nose/Throat**
- ☐ Visual changes
- ☐ Sinus problems
- ☐ Hearing loss
- ☐ Difficulty swallowing/chewing
- ☐ Double vision
- ☐ Head injury/trauma
- ☐ Ringing in ears
- ☐ TMJ/TMD
- ☐ Headaches

**Cardiovascular**
- ☐ Chest pains
- ☐ Shortness of breath
- ☐ High/low blood pressure
- ☐ Blood clots
- ☐ Palpitations
- ☐ Fainting
- ☐ Heart disease
- ☐ Cold hands/feet
- ☐ Poor clotting

**Respiratory**
- ☐ Cough
- ☐ Cough up blood
- ☐ TB
- ☐ Sputum
- ☐ Asthma/wheezing
- ☐ COPD/Emphysema

**Gastrointestinal**
- ☐ Abdominal pain
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Nausea
- ☐ Constipation
- ☐ Indigestion

**Musculoskeletal**
- ☐ Neck/back pain
- ☐ Stiff neck
- ☐ Joint pain/stiffness
- ☐ Hip/knee/ankle pain
- ☐ Plantar fasciitis
- ☐ Scoliosis
- ☐ Joint swelling
- ☐ Shoulder/elbow/wrist pain

**Neurologic**
- ☐ Dizziness
- ☐ Seizures
- ☐ Weakness
- ☐ Numbness/tingling
- ☐ Migraine/cluster headaches

**Other**
- ☐ Diabetes
- ☐ Cancer
- ☐ Fibromyalgia
- ☐ Nervous/anxiety
- ☐ Depression
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Varicose veins
- ☐ Anaphylaxis

**Have you broken any bones?** ☐ **Yes** ☐ **No**

Name of medication: _____ Reason for taking: _____

Name of medication: _____ Reason for taking: _____

Name of medication: _____ Reason for taking: _____

**DOCTORS NOTE**

**WOMEN ONLY**

- ☐ Painful menstruation
- ☐ Irregular cycle
- ☐ Breast problems
- ☐ Menopause

Are you pregnant?

☐ Yes ☐ No ☐ Maybe

_____

Signed by (please print)

_____

Signature Date