



Confidential Health History

Today's Date _____

Name _____ Birth Date _____ Age _____ Height _____' - _____" Weight _____ lbs

Address _____ City _____ State _____ Zip _____

Phone: _____ Cell: _____ Email: _____

May we thank who referred you? _____ Sign Internet Yellow pages Hotel

Who is your primary medical doctor/health care provider? _____

Please List Your Problem(s)

Rate Your Pain (Circle least & worst)

1.) _____ 0 1 2 3 4 5 6 7 8 9 10

My Pain is → Dull, Achy, Numb, Sharp, Shooting, Spasm, Burning, Tingling, Throbbing, Weakness Other

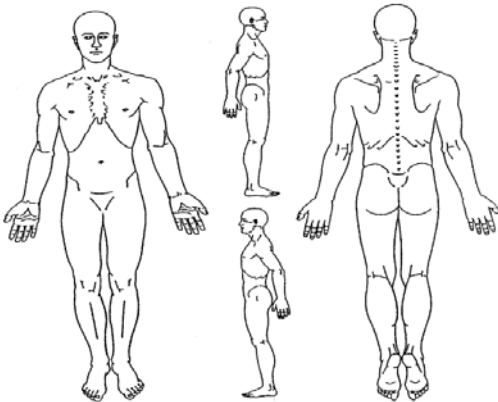
I feel it → Constantly (> 76% of day), Frequently (51-75%), Occasionally (26-50%), Intermittently (< 25%) of the time.

2.) _____ 0 1 2 3 4 5 6 7 8 9 10

My Pain is → Dull, Achy, Numb, Sharp, Shooting, Spasm, Burning, Tingling, Throbbing, Weakness Other

I feel it → Constantly (> 76% of day), Frequently (51-75%), Occasionally (26-50%), Intermittently (< 25%) of the time.

↓ Mark PAIN Areas ↓



WHEN did this begin? _____

WHAT caused it? _____

Have you ever had this before? No (First time), Yes - once before, several times, many times Other

Is it getting: Better Same Worse Other

Does the Pain RADIATE?

No / Yes, to my Head Shoulder Arm Buttock Thigh Leg Foot
 other

What makes it feel BETTER? Nothing/ sitting standing walking movement ice heat exercise massage

Drugs (list)

other (explain)

What makes it WORSE? lying down sitting standing walking movement ice heat exercise Other (explain)

Is it Worse: morning evening at night always the same Other

Have you had any Treatment for this Current Problem? No/ Yes → medical chiropractic physical therapy massage

Acupuncture ice heat drugs _____ Did it help? Yes/ No

Have you ever had Chiropractic Care before? No/Yes → Same Problem, Different (explain)

When was your Last Adjustment? # _____ (days, weeks, months, years) Dr? _____

Your Occupation/Type Work Activity: _____

Work activity: Office Work → # _____ hours sitting per day? Physical Work → Light Moderate Heavy

Is this problem affecting your ability to Work, Play, Exercise, or perform your normal Activities of Daily Living?

No/Yes → I can do with mild annoyance, I can do, but it hurts, I cannot do (too much pain)

Other (explain)

Any SIGNIFICANT Past Injuries / Accidents / Falls? No/Yes (explain)

Surgery? No/Yes (explain)

Current Medication? No/Yes (explain)

Recent X-rays, MRI, CT Scans or Other Diagnostic Studies? No/Yes (explain)

Please check all that apply: (C = Current, P = Past)

C P

- Adrenal Fatigue
- Insomnia mild moderate severe
- Headaches
- Thyroid; hypo hyper
- Goiter
- Depression mild moderate severe
- Fibromyalgia
- Allergy Shots
- Anemia
- Bronchitis
- Asthma / Emphysema
- Pneumonia
- Breast Lumps
- Cancer _____
- Cataracts / Glaucoma
- Pinched Nerve
- Herniated Disk
- Heart disease
- High Cholesterol
- High Blood Sugar

C P

- High Blood Pressure
- High Triglycerides
- Coronary Artery disease (CAD)
- Atherosclerosis
- Pacemaker
- Stroke
- Hypoglycemia
- Insulin Resistance
- Diabetes – type 1 type 2
- Central Obesity
- Metabolic Synd/Syndrome X
- IBS (Irritable Bowel Syndrome)
- Crohn's disease
- Diverticulitis -osis
- Kidney disease / stones
- Liver disease
- Gallbladder disease / stones
- Multiple Sclerosis
- AIDS/HIV
- Limes Disease

C P

- Herpes
- Chickenpox
- Hepatitis
- Mumps
- Measles
- Osteoarthritis
- Rheumatoid Arthritis
- Gout
- Osteoporosis
- Parkinson's disease
- PCOS
- Rheumatic Fever
- Scarlet Fever
- Tuberculosis (TB)
- Ulcers
- Ulcerative Colitis
- Benign Prostatic Hypertrophy
- Menstrual Problems
- Urinary Tract Infections (UTI)
- _____

Any Other Health Problems? No/Yes (explain)

Significant Family History of Illness? No/Yes (explain)

Is there anything else you think the doctor should know, or general health concerns? No/Yes (explain)

OUR FINANCIAL POLICY

Your first visit is \$85.00. X-Rays are usually \$70.00 to \$115.00. Follow up visits are \$40.00. Nutritional evaluations are \$150. We do not bill insurance. On request we will provide you with a statement you can submit to your insurance company for direct reimbursement.

Patient/Parent/Guardian Signature _____ Date _____