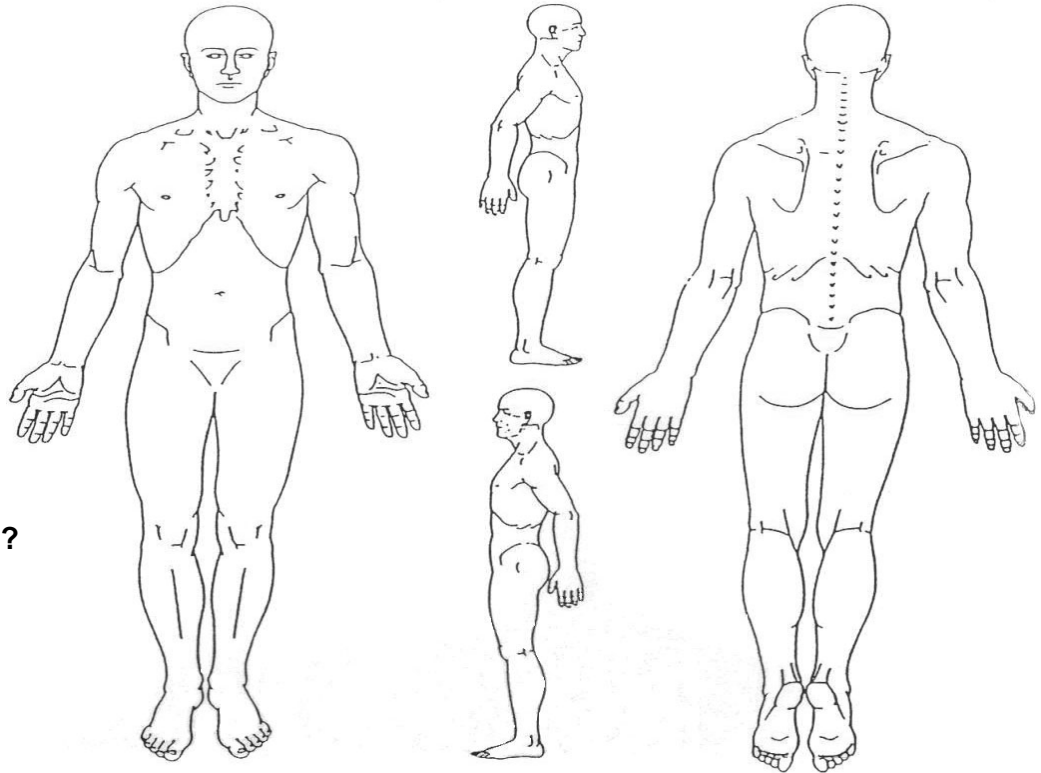


Health History Form

Patient's Name _____ Date _____
 Address _____ City _____ State _____ Zip _____
 Phone _____ Date of Birth _____ Age _____ Sex _____
 Email _____

Please mark the area and type of pain on the drawing using the following code:

- N** – Numbness
- P** – Pain
- T** – Tingling
- A** – Ache
- S** – Soreness
- ST** – Stiffness



What are your chief complaints?

1. _____
2. _____
3. _____

Right

Left

Left

Left

Right

HABITS

- Smoking Packs/Day _____
- Drinking Alcohol _____
- Coffee Cups/Day _____

EXERCISE

- None
 - Moderate
 - Daily
- Type _____

FAMILY HISTORY

	Diabetes	Heart	Kidney	Cancer	Back
Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sister	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

- | | | | |
|--|--------------------------------------|---|--|
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Measles | <input type="checkbox"/> Goiter | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Mumps | <input type="checkbox"/> Influenza | <input type="checkbox"/> Mental Disorder |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Lumbago |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Cancer | <input type="checkbox"/> Venereal Infection | <input type="checkbox"/> HIV Positive |

OPERATIONS AND PROCEDURES

DATE(S)		DATE(S)		DATE(S)	
_____	Vaccinations	_____	Tubes in Ears	_____	Sinus
_____	Tonsillectomy	_____	Appendectomy	_____	Hernia
_____	Gall Bladder	_____	Female Organs	_____	Thyroid
_____	Back Operation	_____	Rectal Surgery	_____	Stomach
_____	Other	_____	Other	_____	Other

Please Check One: Never – N, Previously – P1, Presently – P2

GENERAL SYMPTOMS

- Bronchitis
- Chills
- Convulsions
- Dizziness
- Fainting
- Fatigue
- Fever
- Headache
- Loss of sleep
- Loss of weight
- Nervousness
- Neuralgia
- Night sweats
- Numbness/pain in arms/legs/hands
- Wheezing
- Allergy to what: _____

MUSCLES & JOINTS

- Backache
- Foot trouble
- Hernia
- Pain between shoulders
- Painful tailbone
- Stiff neck
- Spinal curvature
- Swollen joints
- Tremors
- Twitching
- Weakness

GASTRO-INTESTINAL

- Belching or gas
- Colon trouble
- Constipation
- Diarrhea
- Excessive hunger
- Gall bladder trouble
- Hemorrhoids (Piles)
- Jaundice
- Liver trouble
- Nausea
- Pain over stomach
- Poor appetite
- Poor digestion
- Vomiting
- Vomiting blood

CARDIO-VASCULAR

- High blood pressure
- Low blood pressure
- Pain over heart
- Poor circulation
- Heart trouble
- Rapid heart
- Slow heart
- Stroke
- Swollen ankles
- Varicose veins

EAR/NOSE/THROAT

- Asthma
- Crossed Eyes
- Deafness
- Earache
- Ear discharge
- Ear noise
- Enlarged thyroid
- Frequent colds
- Hay fever
- Hoarseness
- Nasal obstruction
- Nose bleeds
- Pain in eyes
- Poor vision
- Sinusitis
- Sore throats
- Tonsillitis

SKIN OR ALLERGIES

- Boils
- Bruise easily
- Dryness
- Eczema
- Hives or allergy
- Itching
- Sensitive skin
- Skin eruptions

RESPIRATORY

- Chest pain
- Chronic cough
- Difficulty breathing
- Spitting blood
- Spitting phlegm

GENITO-URINARY

- Bed wetting
- Blood in urine
- Frequent urination
- Inability to control urine
- Kidney infection
- Painful urination
- Prostate trouble

FOR WOMEN ONLY

- Cramps or backaches
- Excessive flow
- Hot flashes
- Irregular cycle
- Miscarriage
- Painful periods
- Vaginal discharge
- Pregnant at this time?

List any accidents or falls and dates: Car _____ Recreation Vehicle _____
 Sports _____ School _____ Other _____

List any broken bones (fractures) or dislocations: _____

Were you ever on crutches? No Yes Why? _____

Have you ever had X-rays taken? No Yes When? _____

For what ailments were these X-rays taken? _____

Have you ever had any spinal taps or spinal injections? No Yes

Were you ever knocked unconscious? No Yes Have you ever had a lapse of memory? No Yes

Do you suffer from any condition other than that which has been listed previously? _____

Are you currently taking any medication - prescription or over-the-counter? No Yes

What: _____

I have completed this 3-page form to the best of my ability.

Signature: _____ Date: _____