

Doctor's Name _____ Referred By _____ Date _____

File #: _____

PATIENT HEALTH HISTORY

Re-evaluation: [] Yes

Please write legibly to avoid inaccuracies and delays when processing your information.

1. Name: _____ Gender: [] M, [] F Age: _____ Height: _____ Weight: _____
Address: _____ City _____ State _____ Zip _____
Cell Phone: _____ Home Phone _____ Birth Date _____
Email _____
Primary Physician: _____ Phone: _____ Fax: _____

2. Have you ever used: [] Chiropractic Treatment [] Chinese Herbal Medicine [] Acupuncture [] Homeopathy
If yes, for which conditions? _____
If no, would you like to hear about options for your condition (please circle)? Yes No

3. What is the reason for your visit? What is your chief complaint? (Describe your condition at its worst)

Other Complaints: _____
Diagnosed Medical Conditions: _____

4. Cause of Health Conditions: [] Injury [] Auto Accident [] Personal Injury [] Other: _____
Has the accident been reported? Yes No Reported to: [] Employer [] Auto Carrier [] Other: _____
Are you now or have you ever been disabled? Yes No Date: _____ Cause: _____
Have you ever retained an attorney? Yes No Name: _____ Phone: _____

5. Pain Symptoms: a. _____ Began (Mo/Yr) _____ Previous Episodes (Mo/Yr) _____
(In Order b. _____ Began (Mo/Yr) _____ Previous Episodes (Mo/Yr) _____
of Severity) c. _____ Began (Mo/Yr) _____ Previous Episodes (Mo/Yr) _____

6. Please indicate areas of pain or discomfort and mark them using the codes listed below:

N=Numbness, T=Tingling, B=Burning, P=Pain, S=Soreness, A=Ache, SB=Stabbing, SF=Stiffness, X=Scars

List the frequency and severity of your condition on a scale of 1 to 5:

Frequency:	Severity:
1=20% of the time	1=Annoying
2=40% of the time	2=Impairment to Activity
3=60% of the time	3=Need Medication
4=80% of the time	4=Impairment with Medication
5=100% of the time	5=Severe (Need Hospitalization)

Location/Body Part	Frequency	Severity	Initial Cause	Getting Worse?
a. _____	_____	_____	_____	Yes No
b. _____	_____	_____	_____	Yes No
c. _____	_____	_____	_____	Yes No

Does it affect other areas of your body (please circle)? Yes No

If yes, explain: _____

7. Do you have, or have you ever had:

Osteoarthritis _____	Bone Spurs _____	Non-union Fracture _____	Ganglion or Baker's Cyst _____
Bulging Disc _____	Tendonitis _____	Avascular Necrosis _____	Cartilage injury _____
Herniated Disc _____	Joint Separations _____	Post-herpetic neuralgia _____	(Meniscus Tear, Chondromalacia
DDD _____	Bursitis _____	Intercostal Neuralgia _____	Patellar Syndrome)
Stenosis _____	Sprains _____	Morton's Neuroma _____	

8. Does the condition interfere with (please check): Work Sleep Other: _____

Please describe: _____

Without treatment, how would it affect your quality of life? _____

☐ Blood in Stool
☐ Mucous in Stool
☐ Black Stool
☐ Stomach Pains/Cramps
☐ Abdominal Pain
☐ Abdominal Spasms
☐ Lack of Bowel Control
☐ Itchy Anus
☐ Rectal Pain
☐ Hemorrhoids
☐ Anal Fissures
 Bowel Movements: ☐
 Frequency: ☐
 Texture/Form ☐
 Color ☐
 Odor ☐

General

☐ Sweat Easily
☐ Night Sweats
☐ Gallbladder Trouble
☐ Cold Hands or Feet
☐ Poor Circulation
☐ Spitting Blood
☐ Fever
☐ Chills
☐ Muscle Cramps
☐ Lower Extremity Edema
☐ Vertigo or Dizziness
☐ Bleed or Bruise Easily
☐ Frequent Illness
☐ Seasonal Allergy
☐ Addicted to Drugs
☐ Addicted to Smoking
☐ Peculiar Taste:
 Describe: ☐

Respiratory

☐ Tight Chest
☐ Shortness of Breath
☐ Difficulty Breathing
 When Lying Down
☐ Itching Inside the Chest
☐ Wheezing
☐ Persistent Cough
☐ Coughing Blood
☐ Cough: Wet / Dry, Thick / Thin
 Color of Phlegm ☐
☐ Other Lung Problems

Urinary

☐ Bedwetting
☐ Blood in Urine
☐ Lack of Bladder Control
☐ Pain During Urination
☐ Frequent/urgent urination
☐ Incomplete Urination
☐ Difficulty Urination
☐ Wake to Urinate
☐ Prostate Problem
☐ Genital Itch or Discharge
☐ Premature Ejaculation
☐ Recurrent Bladder Infections
☐ Impotence
☐ Increased Libido
☐ Decreased Libido

Weight & Eating

☐ Recent Weight Loss
☐ Recent Weight Gain
☐ Binge Eating/Drinking

☐ Craving Certain Foods
 Describe: ☐
☐ Excessive Weight
☐ Loss of Taste
☐ Compulsive Eating
☐ Poor Appetite
☐ Heavy Appetite
☐ Strongly Like Cold Drinks
☐ Strongly Like Hot Drinks
☐ Water Retention

Musculoskeletal

☐ Muscle Pains
☐ Muscle Cramps
☐ Pains or Aches in Joints
☐ Stiffness/Limited Range of Motion
☐ Pains or Aches in Muscles
☐ Feeling of Weakness/Tiredness
☐ Swollen Tender Joints
☐ Pain in Legs
☐ Hip Tightness/Coldness/Pain
☐ Rib Pain
☐ Neck/Shoulder Pain
☐ Upper Back Pain
☐ Back Pain
☐ Lower Back Pain
☐ Sciatic Pain

Cardiovascular

☐ Heart Murmur
☐ Heart Palpitations
☐ Irregular or Skipping Heartbeat
☐ Rapid or Pounding Heartbeat
☐ Chest Pain
☐ Difficulty Breathing
☐ High Blood Pressure
☐ Low Blood Pressure
☐ Blood Clots
☐ Anemia
☐ Fainting
☐ Tachycardia

Emotions

☐ Mood Swings
☐ Anxious, Fear, Nervous
☐ Angry Irritable, Aggressive
☐ Easily Stressed
☐ Argumentative
☐ Frustrated, Cries Easily
☐ Depression
☐ Abuse Survivor
☐ Considered/Attempted Suicide
☐ Seeing a Therapist
☐ Obsessive Behavior
☐ Compulsive Thoughts
☐ Uncontrollable Urges

Mind

☐ Poor Memory
☐ Difficulty Completing Projects
☐ Difficulty with Mathematics
☐ Underachiever
☐ Poor/Short Attention Span
☐ Confusion
☐ Easily Distracted
☐ Difficulty Making Decisions
☐ Learning Disability

Neurological

☐ Seizures

☐ Numbness
☐ Tics
☐ Foot Neuropathy

Energy & Activity

☐ Apathy, Lethargy
☐ Attention Deficit
☐ Fatigue
☐ Lack of Strength
☐ Body Heaviness
☐ Hyperactivity
☐ Restlessness
☐ Shortness of Breath
☐ Stuttering or Stammering
☐ Slurred Speech

Ears

☐ Itchy Ears
☐ Ear Aches, Ear Infections
☐ Drainage from Ears
☐ Hearing Loss
☐ Reddening of the Ears
☐ Ringing in the Ears
☐ Headaches
☐ Concussions

Nose

☐ Stuffy Nose
☐ Dryness Inside the Nose
☐ Chronically Red,
 Inflamed Nose
☐ Sinus Problem
☐ Hay Fever
☐ Sneezing Attacks
☐ Excessive Mucous Formation
☐ Back Dripping
☐ Nose Bleeding

Eyes

☐ Glasses/Contacts
☐ Watery or Itchy Eyes
☐ Red, Swollen or Sticky Eyelids
☐ Bags/Dark Circles Under Eyes
☐ Poor Vision
☐ Blurred or Tunnel Vision
☐ Sensitive to Sunlight
☐ Eye Strain
☐ Eye Pain
☐ Red Eyes
☐ Itchy Eyes
☐ Easily Fatigued Eyes
☐ Spots in Eyes
☐ Night Blindness
☐ Glaucoma
☐ Cataract

Head

☐ Headaches
☐ Migraines
☐ Faintness
☐ Dizziness
☐ Facial Flushing
☐ Facial Pain
☐ TMJ

Sleep

☐ Insomnia
☐ Sleep Disorder
☐ Difficulty Falling Asleep
☐ Difficulty Staying Asleep

☐ Wakes Up Frequently
☐ Morning Shakiness
☐ Cannot Wake Up in Morning

Mouth & Throat

☐ Chronic Coughing
☐ Gagging, Often Clearing Throat
☐ Sore Throat, Hoarse, Voice Loss
☐ Swollen/Discolored Tongue/Lips
☐ Sores on Lips or Tongue
☐ Canker Sores
☐ Itching on Roof of Mouth
☐ Dry Mouth
☐ Excessive Saliva
☐ Recurrent Sore Throat
☐ Excessive Phlegm
 Color: ☐
☐ Swollen Glands
☐ Lumps in Throat
☐ Enlarged Thyroid
☐ Teeth Problem
☐ Gum Problem
☐ Grinding Teeth

Skin & Hair

☐ Acne
☐ Itching
☐ Hives
☐ Rash
☐ Eczema
☐ Dry Skin
☐ Ulcerations
☐ Hair Loss
☐ Dandruff
☐ Flushing or Hot Flashes
☐ Change in Hair/Skin Texture
☐ Loss in Pigmentation
☐ Skin Fungal Infections

For Women Only

Age Menstrual Cycle Began: ☐

Length of Cycle (Day 1 - Day 1): ☐

Duration of Flow: ☐

☐ Dark Color Flow
☐ Clots in Flow
☐ Excessive Flow
☐ Irregular Cycle
☐ Painful Period
☐ Painful Intercourse
☐ Excessive Vaginal Discharge
☐ Menopause Symptoms
☐ Lump in Breast
☐ Vaginal Dryness
☐ Vaginal Sores
☐ Vaginal Odor
 Vaginal Discharge Color: ☐

of Pregnancies: ☐

of Live Births: ☐

of Premature Births: ☐

Age at Menopause: ☐

Date Last Period Began: ☐

Any Other Symptoms:

☐
☐

17. Operations and Procedures

Date	Date	Date	Other:
_____ Vaccinations	_____ Tubes in Ears	_____ Sinus	_____
_____ Tonsillectomy	_____ Appendectomy	_____ Hernia	Date: _____
_____ Gallbladder	_____ Gynecological	_____ Thyroid	
_____ Back Operation	_____ Rectal Surgery	_____ Stomach	

List and date any accidents or falls (please check):

[] Car _____, [] Recreation _____, [] Sports _____, [] School _____, [] Other _____

List any broken bones: _____

Have you ever had spinal taps or spinal injections (please check)? Yes No Date: _____

Have you ever lost consciousness (please check)? Yes No Why? _____

Have you ever had X-ray taken? Yes No Date: _____ By Whom? _____

For what ailment were these X-rays taken? _____

Do you suffer from any condition other than that for which you are now consulting us? _____

I understand and agree that health and accident insurance policies are an arrangement between the insurance company and me. The health care provider's office will prepare necessary paperwork to assist me in the filing insurance claims but cannot guarantee reimbursement. Direct payments made from the insurance company to the health care provider's office will be credited to my account upon receipt and any balances due will be my responsibility. All services rendered to me are my personal responsibility and I agree to make payments for these services to the health care provider's office. I also understand that if I suspend or terminate my care and treatment, any fees for services rendered will be immediately due and payable. Should third party collection become necessary, I agree to pay all fees involved in collections of the account.

I authorize the health care provider to examine and treat my condition as deemed appropriate through the use of chiropractic care, acupuncture, Traditional Chinese Medicine, and/or other natural healing methods.

Patient's / Guardian's Signature: _____ **Date:** _____