HEALTH HISTORY FORM

Name: | Date:

Current Problem: Please describe the problem(s) that brings you into our clinic today:

❑ Neck pain ❑ Headache ❑ Mid back pain ❑ Low back pain ❑ Other:

❑ Marked Morning Pain or Stiffness ❑ Pain at night ❑ Pain wakes you up at night ❑ Abnormal Weight: ❑ Gain ❑ Loss

Date Problem Began: | Is This? ❑ Work-related ❑ Auto-related

How Problem Began:

How often are your symptoms present? ❑ 0-25% ❑ 26-50% ❑ 51-75% ❑ 76-100%

Circle two numbers below to indicate your pain at its best and at its worst:

Current complaint (how you feel today): |_____|

0 (No Pain) 1 2 3 4 5 6 7 8 9 10 (Unbearable Pain)

What treatment have you already received for this problem/condition? ❑ Acupuncture ❑ Chiropractic ❑ Massage ❑ Naturopathy ❑ Osteopathy

❑ Physical Therapy ❑ Psychology ❑ Vocational Rehab Counselor ❑ Other Specialist : *(Please list, e.g. Neurologist, Orthopedist):*_____

Name of your current Primary Medical Physician: _____

Name of other doctor(s) who have treated you for your condition: _____

Place a check mark in the appropriate "Yes" or "No" box to indicate if you have EVER been diagnosed or received treatment with following:

AIDS/HIV	❑ Yes ❑ No	Hepatitis	❑ Yes ❑ No
Ankylosing Spondylitis	❑ Yes ❑ No	High Blood Pressure	❑ Yes ❑ No
Aortic Aneurysm	❑ Yes ❑ No	High Cholesterol	❑ Yes ❑ No
Arterial Blockage	❑ Yes ❑ No	Hyper or Hypo Thyroid	❑ Yes ❑ No
Arthritis	❑ Yes ❑ No	Kidney Disease	❑ Yes ❑ No
Bleeding Disorders	❑ Yes ❑ No	Liver Disease	❑ Yes ❑ No
Breast Lump	❑ Yes ❑ No	Migraine Headaches	❑ Yes ❑ No
Cancer	❑ Yes ❑ No (If yes, please ✓ below)	Mononucleosis	❑ Yes ❑ No
❑ Bone ❑ Breast ❑ Colon ❑ Leukemia ❑ Lung ❑ Lymphoma		Multiple Sclerosis	❑ Yes ❑ No
❑ Ovarian ❑ Prostate ❑ Skin ❑ Uterine		Parkinson's Disease	❑ Yes ❑ No
❑ Other: _____		Polio	❑ Yes ❑ No
Deep Venous Thrombosis (Blood Clots in Legs)	❑ Yes ❑ No	Pregnancy	❑ Yes ❑ No (No. of births_____)
Degenerative Osteoarthritis	❑ Yes ❑ No	Prostate Problems	❑ Yes ❑ No
Depression	❑ Yes ❑ No	Prosthesis	❑ Yes ❑ No
Diabetes	❑ Yes ❑ No	Rheumatoid Arthritis	❑ Yes ❑ No
Dizziness/Fainting	❑ Yes ❑ No	Stroke	❑ Yes ❑ No
Emphysema	❑ Yes ❑ No	Tuberculosis	❑ Yes ❑ No
Epilepsy/Seizures	❑ Yes ❑ No	Tumors/Growths	❑ Yes ❑ No
Gout	❑ Yes ❑ No	Ulcers	❑ Yes ❑ No
Heart Attack	❑ Yes ❑ No	Urinary Incontinence	❑ Yes ❑ No
Heart Disease	❑ Yes ❑ No	Visual Disturbances	❑ Yes ❑ No
Heart Valve Condition	❑ Yes ❑ No	Other: _____	

Are you pregnant? ❑ Yes ❑ No Due Date: _____

Family History: ❑ Cancer ❑ Diabetes ❑ High Blood Pressure ❑ Cardiovascular Problems ❑ Stroke

EXERCISE:		**WORK ACTIVITY**:		**HABITS:**	
❑ None	❑ Daily	❑ Sitting	❑ Light Labor	❑ Alcohol	Drinks/Week_____
❑ Moderate	❑ Heavy	❑ Standing	❑ Heavy Labor	❑ Coffee/Caffeine Drinks	Cups/Day _____
				❑ High Stress Level	Reason _____

Have you had any surgeries? (Please List):

_____

_____

_____

Within the last 12 months

❑ Yes

❑ Yes

❑ Yes

More than 12 months ago

❑ Yes, date: _____

❑ Yes, date: _____

❑ Yes, date: _____

Injuries you have had:

Motor Vehicle Accident: ❑ Yes ❑ No

Work-related Injuries: ❑ Yes ❑ No

Sports Injuries: ❑ Yes ❑ No

Other :_____

Description: Injuries

_____

_____

_____

_____

Date(s):

_____

_____

_____

_____