

GENERAL HEALTH HISTORY

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Patient Name _____ Mark the conditions that apply to you.

Past	Present	Past	Present
<input type="checkbox"/>	<input type="checkbox"/> Headaches	<input type="checkbox"/>	<input type="checkbox"/> Urinary Problems
<input type="checkbox"/>	<input type="checkbox"/> Migraines	<input type="checkbox"/>	<input type="checkbox"/> Easy Bruising
<input type="checkbox"/>	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/> Tobacco Use
<input type="checkbox"/>	<input type="checkbox"/> Allergies / Asthma	<input type="checkbox"/>	<input type="checkbox"/> Dental Problems
<input type="checkbox"/>	<input type="checkbox"/> Medication Side Effects	<input type="checkbox"/>	<input type="checkbox"/> Fibromyalgia
<input type="checkbox"/>	<input type="checkbox"/> Diabetes	<input type="checkbox"/>	<input type="checkbox"/> Blood Thinner use
<input type="checkbox"/>	<input type="checkbox"/> Hands or Feet cold	<input type="checkbox"/>	<input type="checkbox"/> HIV Positive
<input type="checkbox"/>	<input type="checkbox"/> Muscle aches	<input type="checkbox"/>	<input type="checkbox"/> Cancer
<input type="checkbox"/>	<input type="checkbox"/> Trouble Walking	<input type="checkbox"/>	<input type="checkbox"/> Depression
<input type="checkbox"/>	<input type="checkbox"/> Leg / Foot Numbness	<input type="checkbox"/>	<input type="checkbox"/> Alcohol Use
<input type="checkbox"/>	<input type="checkbox"/> Fainting	<input type="checkbox"/>	<input type="checkbox"/> ___ High or ___ Low Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/> Gall Bladder Trouble	<input type="checkbox"/>	<input type="checkbox"/> Stroke History
<input type="checkbox"/>	<input type="checkbox"/> Ringing in Ears	<input type="checkbox"/>	<input type="checkbox"/> High Cholesterol
<input type="checkbox"/>	<input type="checkbox"/> Ear Problems	<input type="checkbox"/>	<input type="checkbox"/> TMJ
<input type="checkbox"/>	<input type="checkbox"/> Sleeping Problems	<input type="checkbox"/>	<input type="checkbox"/> Digestive Problems
<input type="checkbox"/>	<input type="checkbox"/> Vision Problems	<input type="checkbox"/>	<input type="checkbox"/> Pain all Over
<input type="checkbox"/>	<input type="checkbox"/> Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/> Tension / Irritability
<input type="checkbox"/>	<input type="checkbox"/> Liver Disease	<input type="checkbox"/>	<input type="checkbox"/> Chest Pains
<input type="checkbox"/>	<input type="checkbox"/> Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/> Heart Pacemaker
<input type="checkbox"/>	<input type="checkbox"/> Light Bothers Eyes	<input type="checkbox"/>	<input type="checkbox"/> Heart Problems
<input type="checkbox"/>	<input type="checkbox"/> Other _____		

1. List any medications you are taking: _____

2. Please list all doctors you are currently seeing: _____

3. Has any Doctor or other professional advised you to "Go to a Chiropractor ": No Yes, Name _____

PAST HISTORY

4. List any past auto collisions: _____ Was any care received? _____

5. List any past work injuries: _____ Was any care received? _____

6. List any past sport, recreational, or home injuries _____

7. Please describe any past conditions and treatment received: _____

8. Please list any past hospitalizations and surgeries: _____

FAMILY HISTORY

Father's side: Heart Disease Cancer Diabetes Heavy Medication use Arthritis Other _____

Mother's side: Heart Disease Cancer Diabetes Heavy Medication use Arthritis Other _____

Is there any other family history you want us to know? _____