Name_____ Date_____/_____/_____

History: Check if YOU have now or have had any of the following:

___Fractured bones	___Loss of Memory	___Chest pain
___Auto accidents ____0-1 yrs ago	___Learning Disability	___Asthma
____1-5 yrs ago	___Mistake sidedness (R from L)	___Lung problems
____ more than 5 years ago	___Stutter	___Difficulty breathing
___Other accidents/falls	___Dyslexia	___Wheezing
___Knocked unconscious	___Mood changes	___Heart problems
___Back curvature	___Lose temper easily	___Stroke
___Mental or emotional disorders	___Headache	___High or low blood pressure
___Arthritis	___Neck pain or stiff R or L	___Varicose veins
___Diabetes	___Numbness, tingling, or pain in arms, hands, fingers R or L	___Liver trouble
___Swollen or Painful joints	___Jaw pain or click/TMJ R or L	___Gallbladder trouble
___Convulsions/Epilepsy	___Head seems too heavy	___Digestive problems
___Skin problems	___Head and shoulders feel tired	___Excess gas
___Itching	___Difficulty in excessive (standing, walking, sitting, riding, bending, lifting, twisting, household duties)	___Belching/bloating after meals
___Bruising	___Shoulder pain R or L	___Heartburn
___Cancer	___Dizziness	___Ulcers
___Frequent Colds/Flu	___Ringing in ears R or L	___Diarrhea/constipation
___Nervous	___Hearing loss R or L	___Colon trouble
___Tension	___Fainting	___Hemorrhoids
___Depressed	___Loss of balance	___Prostate problems
___Irritable	___Blurred or double vision R or L	___Impotence
___Anemia	___Upper back pain or stiffness R or L	___Kidney problems
___Excessive Sweating	___Midback pain or stiffness R or L	___Kidney stones
___Tremors	___Lower back pain or stiffness R or L	___Frequent urination
___Light bothers eyes	___Numbness, tingling or pain in the buttocks, thighs, legs, feet, toes R or L	___Discharge
___Allergy	___Pain with cough, sneeze or strain at the stool	___Menstrual problems/PMS
___Sinus Problems	___Hip pain R or L	___Menopause problems
___Lightheaded upon rising	___Foot trouble R or L	___Breast lumps, soreness, discharge
___Under stress		___Pregnant (now)
___Crave Sweets or Salts		___Bedwetting
___Eating disorders		___Ear infections
___Trouble Sleeping		___Hepatitis
___Trouble Concentrating		___Venereal disease
		___AIDS/HIV

Family History: F (father) M (mother) S (sibling) C (child) *Circle all that apply.*

☐ cancer : F M S C (name types) _____

☐ stroke F M S C ☐ heart attack F M S C ☐ diabetes F M S C ☐ depression F M S C

Most recent Chiropractic care(approx. date - mm/yy) **:** _____/_____ Dr. _____ D.C.

Approximately how many Chiropractic visits have you had in your life: _____

Work activities ☐ physical(factory,trade, lifting,etc.) ☐ sedentary(desk,computer,office,etc.) ☐ combination (some paperwork, some heavy lifting, etc.)

Current work status due to condition: ☐ none missed ☐ light-duty ☐occasionally missed ☐ working part-time ☐ have not returned to work ☐ returned to work but unable to continue ☐ off work then returned on_____/_____/_____ ☐ retired ☐ unemployed

Exercise (not work-related) ☐ none ☐ daily ☐ _____ x/wk ☐ never

Type ☐ cardio ☐ resistance/weights ☐ _____ yoga/pilates

Past treatment for <u>this</u> condition: ☐ none ☐ Chiropractic care ☐ over-the-counter medications ☐ physical therapy ☐ prescription medications ☐ cortisone injections ☐ surgery to area of concern ☐ massage

How long ago? _____ **Did it help?** ☐ yes ☐ no