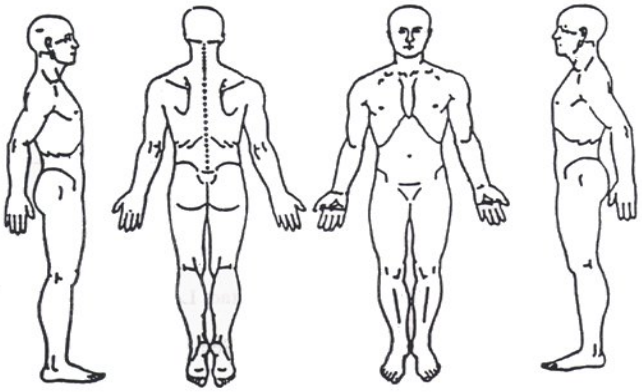
Chiropractic Confidential Health History Date:_____

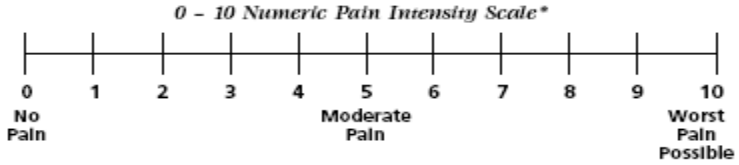
Name _____ Date of Birth _____
Address_____ City_____ Postal Code_____
Home Phone # _____ Other Phone #_____
EMAIL:_____ Occupation_____
Personal Health No._____ Extended Health Plan _____
Medical Doctor _____
Emergency Contact:_____ Emergency Contact Phone #_____
Have you had prior:
Chiropractic Care: YES NO Active Release Therapy: YES NO Prior Massage Therapy: YES NO
Is this a Workers Compensation Care? YES NO Is this a MVA Case? YES NO

Circle the area(s) of complaint and put the number(s) that describe your pain in the appropriate area(s)

1. Aching/Dull/Sore
2. Burning
3. Cramping
4. Numbness/tingling
5. Sharp/Shooting
6. Sharp/Stabbing
7. Snapping/Popping/Grinding
8. Stiffness/Tightness
9. Swelling
10. Throbbing



B. Mark on the line to indicate how severe your pain has been/is currently.



Past Health History

PREVIOUS INJURIES

Please list major past injuries, broken bones, sprains, surgeries, or times you've been struck unconscious.
INJURY DATE PROBLEM NOW

_____
_____
_____

PREVIOUS ILLNESSES

Please list all serious illnesses, such as ASTHMA, CANCER, DIABETES, HEPATITIS, HIGH BLOOD PRESSURE, HIV INJECTION, SEIZURES, TUBERCULOSIS, SICKLE CELL ANEMIA.
DATE DIAGNOSIS TREATMENT GIVEN REMAINING PROBLEMS

_____
_____
_____

MEDICATIONS

Please list all medications you are taking, including over-the-counter drugs, herbs, or vitamins.

NAME REASON DOSAGE TAKEN FOR HOW LONG?

_____

_____

_____

Personal and Social History Please check the appropriate boxes if any of the following apply to you

Past Present

□ □ Tobacco Per Day_____ or Per Week _____ How long (years)

□ □ Alcohol Per Day_____ or Per Week _____

Are you allergic to anything (medications, soap, lotions, food, etc)? YES NO

If Yes, What? _____

Have you recently gained or lost a significant amount of weight? YES NO

If Yes, How much/How? _____

Female Patients, please answer the following questions

Are you pregnant, or do you have any reason to believe that you could be **pregnant**? YES NO

Have you gone through **menopause**? YES NO If yes, was it natural? YES NO

At what age did menopause occur? _____

Family Medical History Please check if any of the following apply to any of your blood relatives:

□	**Alcoholism**	□	**Cancer**
□	**Allergies**	□	**Diabetes Mellitus**
□	**Arthritis**	□	**Heart Disease**
□	**Anemia, blood, bleeding disorders**	□	**Inherited disorder** _____

Symptoms List Please check the appropriate column of symptoms YOU have experienced before (PAST) or the symptoms YOU currently experience (PRESENT):

PAST	PRESENT		PAST	PRESENT	
□	□	**General Fatigue**	□	□	**Skin rash, dermatitis eczema**
□	□	**Headache**	□	□	**Chronic sinus problems**
□	□	**Tinnitus, noises in ear**	□	□	**Excessive thirst**
□	□	**Fainting**	□	□	**Chronic cough**
□	□	**Vision disturbances**	□	□	**Chest pain**
□	□	**Convulsions**	□	□	**Rapid heart beat**
□	□	**Dizziness, light-headedness**	□	□	**Difficulty swallowing**
□	□	**Muscular incoordination**	□	□	**Heartburn, indigestion**
□	□	**TMJ (jaw) pain**	□	□	**Loss of appetite**
□	□	**Neck pain**	□	□	**Nausea**
□	□	**Back pain**	□	□	**Abdominal pain**
□	□	**Swelling of joints**	□	□	**Loss of bladder control**
□	□	**Stiffness of joints**	□	□	**Painful urination**
□	□	**Shoulder pain**	□	□	**Frequent urination**
□	□	**Arm pain**	□	□	**Constipation**
□	□	**Elbow pain**	□	□	**Irregular bowel habits**
□	□	**Wrist, Hand pain**	□	□	**Irregular menstrual flow**
□	□	**Hip pain**	□	□	**Excessive menstrual flow**
□	□	**Leg pain**	□	□	**Breast tenderness, lumps**
□	□	**Knee pain**	□	□	**Vaginal discharge**
□	□	**Ankle, foot pain**	□	□	**PMS**

How did you hear about us? _____

Patient/Guardian signature_____ Date_____