# HEALTH HISTORY

**What treatment have you already received for your condition?** ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None ☐ Other_____

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

**Date of Last:** Physical Exam _____ Spinal X-Ray _____ Blood Test _____
Spinal Exam _____ Chest X-Ray _____ Urine Test _____
Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

**Place a circle around "Yes" or "No" to indicate if you have had any of the following:**

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| AIDS/HIV | Yes | No | Emphysema | Yes | No | Miscarriage | Yes | No | Suicide Attempt | Yes | No |
| Alchoholism | Yes | No | Epilepsy | Yes | No | Mononucleosis | Yes | No | Thyroid Problems | Yes | No |
| Allergy Shots | Yes | No | Fractures | Yes | No | Multiple Sclerosis | Yes | No | Tonsillitis | Yes | No |
| Anemia | Yes | No | Glaucoma | Yes | No | Mumps | Yes | No | Tuberculosis | Yes | No |
| Anorexia | Yes | No | Goiter | Yes | No | Osteoporosis | Yes | No | Tumors, Growths | Yes | No |
| Appendicitis | Yes | No | Gonorrhea | Yes | No | Pacemaker | Yes | No | Typhoid Fever | Yes | No |
| Arthritis | Yes | No | Gout | Yes | No | Parkinson's Disease | Yes | No | Ulcers | Yes | No |
| Asthma | Yes | No | Heart Disease | Yes | No | Pinched Nerve | Yes | No | Vaginal Infections | Yes | No |
| Bleeding Disorders | Yes | No | Hepatitis | Yes | No | Pneumonia | Yes | No | Venereal Disease | Yes | No |
| Breast Lump | Yes | No | Hernia | Yes | No | Polio | Yes | No | Whooping Cough | Yes | No |
| Bronchitis | Yes | No | Herniated Disk | Yes | No | Prostate Problem | Yes | No | Other | | |
| Bulimia | Yes | No | Herpes | Yes | No | Prosthesis | Yes | No | | | |
| Cancer | Yes | No | High Cholesterol | Yes | No | Psychiatric Care | Yes | No | | | |
| Cataracts | Yes | No | Kidney Disease | Yes | No | Rheumatoid Arthritis | Yes | No | | | |
| Chemical Dependency | Yes | No | Liver Disease | Yes | No | Rheumatic Fever | Yes | No | | | |
| Chicken Pox | Yes | No | Measles | Yes | No | Scarlet Fever | Yes | No | | | |
| Diabetes | Yes | No | Migraines | Yes | No | Stroke | Yes | No | | | |

| EXERCISE | WORK ACTIVITY | HABITS | |
|---|---|---|---|
| ☐ None | ☐ Sitting | ☐ Smoking | Packs/day _____ |
| ☐ Moderate | ☐ Standing | ☐ Alcohol | Drinks/week _____ |
| ☐ Daily | ☐ Light Labour | ☐ Coffee/Caffeine Drinks | Cups/day _____ |
| ☐ Heavy | ☐ Heavy Labour | ☐ High Stress Level | Reason _____ |

**Are you pregnant?** Yes ☐ No ☐ Due Date _____

| INJURIES/SURGERIES | DESCRIPTION | DATE |
|---|---|---|
| Falls | | |
| Broken Bones | | |
| Dislocations | | |
| Surgeries | | |

| Medications: | Allergies: | Vitamins/Herbs/Minerals: |
|---|---|---|
| | | |

**Reason for visit?** _____

**When did symptoms appear?** MM / DD / YY **Is pain getting worse?** Y ( ) N ( ) Unsure ( )

**Type of pain:** Sharp( ) Dull( ) Throbbing( ) Numbness( ) Aching( ) Shooting( ) Burning( )
Tingling( ) Cramps( ) Stiffness( ) Swelling( ) Other( ) _____

**Is pain constant?** Y ( ) N ( ) **How often do you have this pain?** _____

**Does pain interfere with:** Work ( ) Sleep ( ) Daily Routine ( ) Recreation ( )

**Activities that are painful:** Sitting ( ) Standing ( ) Walking ( ) Bending ( ) Lying Down ( )