



GENERAL HEALTH HISTORY

Patient Name _____

Mark the conditions that apply to you.

Past Present

- Headaches
- Migraines
- Shortness of Breath
- Allergies / Asthma
- Medication Side Effects
- Diabetes
- Hands or Feet cold
- Muscle aches
- Trouble Walking
- Leg / Foot Numbness
- Fainting
- Gall Bladder Trouble
- Ringing in Ears
- Ear Problems
- Sleeping Problems
- Vision Problems
- Thyroid Problems
- Liver Disease
- Kidney Problems
- Light Bothers Eyes
- Other _____

Past Present

- Urinary Problems
- Easy Bruising
- Tobacco Use
- Dental Problems
- Fibromyalgia
- Blood Thinner use
- HIV Positive
- Cancer
- Depression
- Alcohol Use
- ___High or ___Low Blood Pressure
- Stroke History
- High Cholesterol
- TMJ
- Digestive Problems
- Pain all Over
- Tension / Irritability
- Chest Pains
- Heart Pacemaker
- Heart Problems

1. List any medications are you 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? _____