

GENERAL HEALTH HISTORY

920 Chiropractic Health & Injury Care

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 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? _____