Patient Health History **Patient ID:** _____

Today's Date _____ Signature of Patient _____
(Parent if a minor)
First Name _____ Last Name _____ Middle _____
Street Address _____
City _____ State _____ Zip _____
Home Phone _____ Mobile _____
Work Phone _____ Email _____
Best Contact Method *(check one)* □ Home phone □ Mobile Phone □ Work Phone
Date of Birth _____ Age _____ SS# _____ Gender □ Male □ Female
Marital Status *(check one)* □ Single □ Married □ Other
Spouse's Name _____
Employment Status *(check one)* □ Employed □ FT Student □ Other □ Retired
Employer _____ Occupation/Job Title _____
Race *(Check One)* □ White □ American Indian/Alaska Native □ Asian □ Multi-racial
□ Black or African American □ Hispanic or Latino
□ Native Hawaiian or Pacific Islander □ Some other race
Ethnicity*(Check One)* □ Hispanic/Latino □ Non-Hispanic/Latino

Smoking Status: □ Current every day smoker □ Current some day smoker
□ Former smoker □ Never smoked

List **ALL** current prescription medications. Check here if NONE: □

_____

_____

_____

List **ANY** known allergies you have to medications. Check here if NONE: □

_____

List **ALL** current nutritional supplements, vitamins, etc. Check here if NONE: □

_____

_____

List **ANY** surgical procedures and dates. Check here if NONE: □

_____

_____

Has any doctor diagnosed you with Hypertension presently? □ Yes □ No
Has any doctor diagnosed you with Diabetes presently? □ Yes □ No
If Yes, what kind? □ Type I □ Type II

Have you had an X-Ray, CT scan or MRI of your spine in the past? □ Yes □ No

To be performed by clinic staff:

Height:_____ **Weight:**_____ **Blood Pressure:**_____

HEALTH HISTORY: Check here if NONE: ☐

YOU	FAMILY		YOU	FAMILY	
☐	☐	Diabetes	☐	☐	Thyroid Problems
☐	☐	Heart Attack	☐	☐	Alzheimer's
☐	☐	Stroke	☐	☐	Osteo-Arthrits
☐	☐	Multiple Sclerosis	☐	☐	HIV/AIDS
☐	☐	Parkinson's	☐	☐	Kidney Disease
☐	☐	Headache	☐	☐	Liver Disease
☐	☐	Cardiovascular Disease	☐	☐	Osteoporosis or Osteopenia
☐	☐	Rheumatoid Arthritis	☐	☐	Fibromyalgia and/or Chronic Fatigue Syndrome
☐	☐	High Cholesterol	Controlled by meds? Y / N		
☐	☐	High Blood Pressure	Controlled by meds? Y / N		
☐	☐	Cancer(s) _____			
☐	☐	Other _____			

Stress Levels: ☐ None ☐ Minimal ☐ Moderate ☐ High Source(s) of stress?_____
Sleep: Average # hours_____ Favorite Sleep Position: ☐ Back ☐ Side Lt/Rt ☐ Stomach
Do you have orthodics or lifts in your shoes? ☐ No ☐ Yes, How old?_____
Water: ☐ I consume _____servings/day. ☐ I don't consume extra water
Alcohol: ☐ I don't drink alcohol ☐ I drink an alcoholic beverage_____(#)/day, or_____(#)/week.
*Check **ALL** that apply:* ☐ Beer ☐ Wine ☐ Mixed Liquor Drinks
Caffeine: ☐ I don't consume caffeine ☐ I consume_____servings/day **IN MY** ☐ Soda ☐ Coffee ☐ Tea
Types of EXERCISE & Frequency:_____
Name of previous Chiropractor?_____Date of last visit?_____

CURRENT SYMPTOMS: (Check all that apply)

☐ Headaches/Migraine	☐ Arm tingling
☐ Neck pain/stiffness	☐ Finger numbness
☐ Back pain/stiffness	☐ Jaw pain/popping
☐ Ears Ringing	☐ Sinus problems
☐ Leg tingling	☐ Foot numbness
☐ Facial Pain	☐ Dizziness/Vertigo

When did symptoms begin?_____

Does pain radiate to: ☐ Head R/L ☐ Shoulder R/L ☐ Arm R/L ☐ Buttock R/L ☐ Leg R/L
Do you have any other symptoms not listed above?_____
Are you experiencing any difficulty with:
☐ Sitting ☐ Sitting to Standing ☐ Standing straight ☐ Bending/Twisting
☐ Lying Down ☐ Lifting ☐ Walking ☐ Reaching
Is the pain worse in the...☐ Morning or ☐ Evening **and after** ☐ Normal or ☐ Increased activity.
The pain interferes with my...☐ Work ☐ Sleep ☐ Personal activity ☐ Other_____.
Using the 0-10 scale below, how would you rate your symptoms overall?
(0)No Symptoms (1-2) Mild (3-4) Uncomfortable (5-6) Moderate (7-8) Severe (9-10) Unbearable
Are there any other contributing factors you would like to discuss with the Doctor?_____

Women Only: (For x-ray purposes) Is there any possibility of being pregnant? ☐ Yes ☐ No

Doctor's Signature_____Date_____