

CURRENT HEALTH CONDITION

Current health complaints/reason for consulting our office:

1. _____ For how long? _____
2. _____ For how long? _____
3. _____ For how long? _____

Were other doctors seen for this condition? Yes No Who? _____ Results: _____

Has this condition occurred before? Yes No When? _____

Are your injuries the result of an accident? Yes No How did it occur? _____

Drugs currently taking (**check all that apply**):

- Prescription Over-the-counter Antibiotics Other

Describe: _____

Please describe your daily activities for work, home, or school such as sitting, lifting, phone use, etc.:

PAST HEALTH HISTORY

Have you had an accident, even as a passenger, in a(n) (**check all that apply**):

- Automobile Motorcycle Bicycle Other

Explain with dates: _____

Medical interventions (**check all that apply**):

- Hospitalizations Surgery Physiotherapy Organ Removal Other

Explain with dates: _____

Falls (**check all that apply**):

- Tree Bicycle Skates Steps On ice Abuse
 Broken Bones Physical fight Armed forces Unconscious Sports injuries

Explain with dates: _____

Do you consume (**check all that apply**): Alcohol Coffee/caffeine Tobacco Recreational drugs

If so, how much? _____

Exercise: None Moderate Daily **Diet:** Poor Fair Good

Have you ever had any of the following diseases? (check all that apply):

- Heart Disease Chicken Pox Polio Tuberculosis Epilepsy
 Diabetes Cancer Sexually Transmitted Diseases HIV/AIDS

WOMEN: Are you pregnant? Yes No Date of last menstrual period: _____

What do you wish to gain from Chiropractic care? _____

Check any of the following conditions you have had in the past six months:

Musculo-skeletal

- Low Back Pain
- Pain Between Shoulders
- Neck Pain
- Arm Pain
- Joint Pain/Stiffness
- Walking Problems
- Difficulty Chewing/Clicking Jaw
- General Stiffness
- Arthritis

Nervous System

- Nervous
- Numbness
- Paralysis
- Dizziness
- Forgetfulness
- Confusion/Depression
- Fainting
- Convulsions
- Cold/Tingling Extremities
- Stress

General

- Fatigue
- Allergies
- Loss of Sleep
- Fever
- Headaches

EENT

- Vision Problems
- Dental Problems
- Sore Throat
- Earaches
- Hearing Difficulties
- Stuffed Nose

Gastrointestinal

- Poor/Excessive Appetite
- Excessive Thirst
- Frequent Nausea
- Vomiting
- Diarrhea
- Constipation
- Hemorrhoids
- Liver Problems
- Gall Bladder Problems
- Weight Trouble
- Abdominal Cramps
- Gas/Bloating After Meals
- Heartburn
- Black/Bloody Stools
- Colitis

Genito-urinary

- Bladder Trouble
- Painful/Excessive Urination
- Discolored Urine
- Kidney Stones

Cardiovascular

- Chest Pain
- Shortness of Breath
- Blood Pressure Problems
- Irregular Heartbeat
- Heart Problems
- Lung Problems/Congestions
- Asthma
- Varicose Veins
- Ankle Swelling
- Stroke

Male/Female

- Menstrual Irregularity
- Menstrual Cramps
- Vaginal Pain
- Vaginal Infections
- Breast Pain/Lumps
- Prostate Problems
- Sexual Dysfunction
- Other Problems

Please outline the area(s) of your discomfort

