

Health History Questionnaire

Please take the time to fill out this questionnaire carefully. If you have any questions, ask for assistance. If you have concerns that are not listed, make note of them in the comments section. The completed form will greatly assist us in providing a thorough evaluation of your health.

Confidential Patient Profile

Name: _____ Age: _____ Date of Birth: _____ Sex: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: Home _____ Work _____ Cell: _____

Email address _____ Height: _____ Weight: _____

Social Sec. #: _____ Occupation: _____ Employer: _____

Spouse's Name (if applicable) _____

Emergency Contact Name / Phone: _____ Relationship: _____

Chief Complaint: *In this section please list in order of importance your health concerns.*

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Current Medication List: *In this section please list all pharmaceutical medication(s) that you are currently taking along with dosage and frequency*

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Are you allergic to any medications, food or anything in the environment? Yes _____ No _____

If "Yes", please list your allergies: _____

Hospitalizations & Surgical History: *include reason and year*

- | | | | |
|-----------------------|------------|-----------------------|------------|
| 1 st _____ | Year _____ | 5 th _____ | Year _____ |
| 2 nd _____ | Year _____ | 6 th _____ | Year _____ |
| 3 rd _____ | Year _____ | 7 th _____ | Year _____ |
| 4 th _____ | Year _____ | 8 th _____ | Year _____ |

Current Supplement List: *In this section please include all homeopathics, herbs, vitamins, minerals you are currently taking with dosage.*

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Social History:

Are you currently: Married _____ Divorced _____ Single _____ Long-Term Relationship _____ Widowed _____
 Number of children and ages? _____

Health Habits:

	Yes	No	If "yes", how long or how much per week?
Do you exercise?			
Do you smoke tobacco? Now or in the past.			
Do you drink alcohol?			
Do you use recreational drugs?			
Do you drink coffee, soda or black tea?			
Do you drink "diet" sodas or eat "diet" foods?			
Previous chiropractic care?			
Do you follow any dietary modifications?			If yes, please describe:

Past Medical History: *In this section, please check the appropriate box that applies to you.*

Illness	Now	Past	Illness	Now	Past
Allergies			Gout		
ADD/ADHD			Headaches or Migraine		
Alcoholism			Heart Murmur		
Altered sense: (e.g. taste, smell)			Hemorrhoids		
Anemia			High Blood Pressure		
Anxiety/Depression			HIV/AIDS		
Arthritis			Hyperthyroid		
Asthma			Hypothyroid		
Bleeding Difficulties			Injury (Serious)		
Blood in Stools			Kidney Disease		
Blurred Vision			Liver Disease/Jaundice		
Cancer			Low blood sugar (hypoglycemia)		
Candida (yeast) infection			Numbness/Tingling		
Chemical Sensitivities			Obesity		
Chronic Fatigue			Ulcers		
Colitis			Ovarian Cysts		
Diabetes			Pneumonia		
Dizziness/Vertigo			Post Traumatic Stress Disorder		
Eczema			Recreational Drug use		
Emphysema			Rheumatoid Arthritis		
Fainting			Schizophrenia		
Fibromyalgia			Seizure/epilepsy		
Genital Herpes			Stroke		

Family History: Complete for those applicable and check box if yes for appropriate relation.

	Mother	Father	Brother(s)	Sister(s)	Mom's Parents	Father's Parents	Child
Cause of death							
Alcoholism							
Alzheimer's Disease							
Anemia							
Asthma, Allergies, Hives							
Autoimmune Disease							
Cancer							
Depression/Suicide							
Diabetes							
Epilepsy							
Gastrointestinal Disease							
Glaucoma							
Heart Disease							
High Blood Pressure							
HIV/AIDS							
Mental Illness							
Obesity							
Parkinson's Disease							
Syphilis							
Tuberculosis							

Review of Systems: In this section, please check the appropriate box.

General:	<input checked="" type="checkbox"/>
Do you usually feel tired or worn out?	
Have you recently been more thirsty than normal?	
Any unusual weight gain or loss recently?	
Do you perspire a lot?	
Do you prefer warm?	
Trouble sleeping	
Skin/Hair/Nails	
Changes in the color of your skin?	
Skin rashes or itching?	
Any unusually dry skin?	
Any growth on your skin that bothers you?	
Any sores or wounds that do not heal?	
Any change in color or size or warts?	
Do you have dry skin or brittle nails?	
Eyes:	
Have you had any pain in your eyes?	
Have you had any blurry vision?	
Are you nearsighted or farsighted (circle one)	
Have you noticed any change in your vision?	
Do you often have itchy eyes?	
Any redness or burning in your eyes?	

Do you see halos around lights?	
Ears, Nose, Throat:	
Do you have any difficulty hearing?	
Do you have any ringing or buzzing in your ears?	
Do you have earaches or discharge from your ears?	
Do you have a lot of nasal stuffiness or sinusitis?	
Any drainage down the back of your throat?	
Do you experience frequent or severe nosebleeds?	
Do you have any lumps in your throat?	
Do you experience sore tongue or mouth?	
Do you have bleeding or easily infected gums?	
Do have excessive saliva?	
Do you have bad breath?	
Respiratory	
Do you have frequent chest colds?	
Do you have a constant or bothersome cough?	
Do you cough up blood?	
Do you have sputum or phlegm between colds?	
Do you have any difficulty breathing?	
Have you noticed any wheezing or whistling?	
Cardiovascular	
Any pain, tightness or pressure in your chest?	

Chest pain when walking or, working hard ?	
Have you ever had an abnormal EKG?	
Do you have swelling of your feet or ankles?	
Any cramps in the calf muscles when you walk?	
Do you wake up at night with difficulty breathing?	
Do you need to sleep on more than one pillow?	
Does your heart ever beat fast or irregularly?	
Do your fingers or toes ever get cold, or get blue?	
Gastrointestinal	
Any change in your eating habits?	
Are there any foods that give you upset or pain?	
Recent nausea or vomiting?	
Do you have excessive gas?	
Have you ever vomited blood?	
Do you have indigestion, heartburn or reflux?	
Recently experienced any trouble swallowing?	
Do you experience constipation?	
Do you experience diarrhea?	
Do you have a poor appetite or are easily satiated?	
Have you ever had blood in your stools?	
Do you have hemorrhoids?	
Do you take laxatives regularly?	
Do you feel bloated after meals?	
Do you experience abdominal pain or cramping?	
Genitourinary	
Do you have any burning or pain on urination?	
Do you have any change in frequency of urination?	
Have you experienced urinary incontinence?	
Do you get up at night to urinate?	
Do you have a problem dribbling urine?	
Have you ever passed blood in your urine?	
Do you have frequent bladder or kidney infections?	
Men, do you have prostate trouble?	
Men, have you ever experienced erectile dysfunction?	
Musculoskeletal	
History of gout?	
Do you have pain in your legs or feet?	

Have you ever been diagnosed with scoliosis?	
Do you have joint pain or stiffness?	
Trouble walking or using your hip or knee joints?	
Do you experience regular pain in your body?	
Central Nervous System	
Do you have frequent or severe headaches?	
Dizzy spells, faintness or lightheadedness?	
Lose track of what happens around you	
Lose the ability to speak for a few seconds?	
Fainted, blacked out or lost consciousness?	
Do you consider yourself a nervous person?	
Do you have trouble remembering recent events?	
Have you ever had convulsions or fits?	
Do you experience insomnia?	
Have you been highly emotional lately?	
Do you experience depression?	
Psychological/mental status	
Do you experience anxiety or panic attacks?	
Hospitalized for a psychological condition?	
Have you ever had any suicidal attempts?	
Do you have suicidal thoughts?	
Do you experience excessive restlessness?	
Do you experience mental confusion?	
Are you critical of yourself?	
Are you critical of others?	
Do you experience mood swings?	
Do you experience loneliness?	
Diagnosed with a psychological condition?	
Environmental Exposure	
Work around known toxic chemicals?	
Have you ever been exposed to chemical solvents?	
Do you use oil paints?	
Do you have mercury amalgam fillings?	
Have you ever been excessively exposed to toxic fumes? i.e., gasoline, exhaust fumes, burning of toxic synthetic materials etc.	

Your Primary Care Provider's (Family Physician): _____

May we send reports and updates to your Primary Care Provider ? () Yes () No

By my signature below, I am authorizing the treating physician to administer diagnostic and treatment procedures deemed necessary for my condition.

Patient's Signature (or Parent/Guardian for minor)

Date