

Chiropractic Health History

****Circle all Yes's and No's****

Family History

Y N Diabetes

Y N Thyroid Disease

Y N Tuberculosis

Y N Kidney Disease

Y N High Blood Pressure

Y N Heart Disease

Y N Cancer

Y N Other_____

General History

Y N Unusual height or weight change

Y N Fever or Chills

Y N Sweats

Y N Allergies

Y N Blood Anemia

Y N Bleeding or Bruising

Y N Fatigue

Y N HIV positive

Y N Heat or cold intolerance

Y N Thyroid Problems

Y N Diabetes

Y N Stroke

Y N Heart Attack

Y N High Blood Pressure

Y N Glandular Problems

Y N Other_____

Eye, Ear, Nose, Throat

Y N Visual Problems

Y N Eye redness, swelling, tearing, itching, pain

Y N Difficulty hearing or Deafness

Y N Ringing in the Ears

Y N Dizziness

Y N Ear growths, discharge or pain

Y N Nosebleeds, pain, growths

Y N Inability to smell

Y N Sinus problems

Y N Hoarseness

Y N Difficulty chewing or swallowing

Y N TMJ pain (jaw pain)

Y N Change in ability to taste

Y N Mouth lesions or growths

Y N Dental problems other than cavities

Y N Other_____

Gastrointestinal System

Y N Nausea

Y N Vomiting

Y N Vomiting blood

Y N Ulcers

Y N Indigestion

Y N Heartburn or Reflux

Y N Abdominal Pain or Swelling

Y N Change in bowel habits

Y N Diarrhea

Y N Constipation

Y N Hernia

Y N Hemorrhoids

Y N Gall Bladder Disease

Y N Liver Disease

Y N Pancreas Disease

Y N Other_____

Lungs

Y N Difficulty Breathing

Y N Persistent Cough

Y N Cough up Blood

Y N Asthma or wheezing

Y N Tuberculosis

Y N Respiratory Infection or Pneumonia

Y N Smoking

Y N Exposure to toxic fumes

Heart

Y N Chest Pain

Y N Racing heart

Y N Swelling of ankles

Y N Fainting

Y N Heart Disease

Y N Arteriosclerosis or Atherosclerosis

Y N Rheumatic Fever

Y N Heart murmurs

Y N Angina

Urinary System

Y N Excessive urination

Y N Urinary urgency or pain

Y N Difficulty starting

Y N Change in color of urine

Y N Urinary Tract Infection

Y N Kidney Infection

Y N Pain in the side

Reproductive System

Y N Genital Lesions

Y N Sexually Transmitted Disease

Y N Genital masses, lesions or pain

Y N Birth control method _____

Y N Breast lumps, masses or pain

Y N Unusual nipple or genital discharges

Y N Implants

Skin / Hair / Nails

Y N Changes in skin texture, temperature, color

Y N Excessive Dryness or Perspiration

Y N Rashes, Itching, Lesions

Y N Unusual growths or Mole changes

Y N Skin Cancer, diagnosed by: _____

Y N Change in hair texture or condition

Y N Change in shape, color, quality of nails

Nervous System

Y N Headaches

Y N Seizures

Y N Tics or Spasms

Y N Loss of Balance

Y N Fainting

Y N Numbness or Tingling_____

Y N Unusual Muscle Weaknesses

Y N Head Injury_____

Y N Stroke

Y N Neurological Disease

Musculoskeletal Disease

Y N Joint Stiffness _____

Y N Range of Motion changes_____

Y N Joint Pain_____

Y N Joint swelling

Y N Muscle cramping

Y N Neck Pain

Y N Upper Back Pain

Y N Pain between shoulder blades

Y N Low Back Pain

Y N Hip, Knee, Ankle, Foot Pain

Y N Shoulder, Arm, Elbow, Wrist, Hand Pain

Y N Fractures_____

Y N Dislocations_____

Y N Sprains_____

Y N Auto Accidents _____

Y N Arthritis _____

Hospital Visits (List all and reasons)

Medications (List all meds, reasons for taking and any side-effects. Include over-the-counter and any vitamins or supplements)

Psychological History

Y N Anxiety

Y N Depression

Y N Hospitalization for Psychological care

Y N Suicide attempts

Y N History of Physical or Mental Abuse

Y N History of Drug Abuse

Childhood History

Y N Did you have any birth trauma?

Y N Were you a natural birth?

Y N Were you in a Breach position?

Y N Were you vaccinated?

Y N Did you have any vaccine reactions?

Y N Breast fed

Y N Bottle fed

Y N Was your development impaired?

Y N Were you born with any birth defects?

List all childhood illnesses _____

Notes:
