Doctor's Name _____ Referred By _____ Date _____ File #:

**PATIENT HEALTH HISTORY** **Re-evaluation:** [ ]Yes

**Please write legibly to avoid inaccuracies and delays when processing your information.**

1. Name: _____ Gender: [ ]M, [ ]F Age: _____ Height: _____ Weight: _____
   Address: _____ City _____ State _____ Zip _____
   Cell Phone: _____ Home Phone _____ Birth Date _____
   Email _____
   Primary Physician: _____ Phone: _____ Fax: _____

2. Have you ever used: [ ]Chiropractic Treatment [ ]Chinese Herbal Medicine [ ]Acupuncture [ ]Homeopathy
   If yes, for which conditions? _____
   If no, would you like to hear about options for your condition (please circle)? Yes No

3. What is the reason for your visit? What is your chief complaint? (Describe your condition at its worst)
   _____
   _____
   Other Complaints: _____
   Diagnosed Medical Conditions: _____

4. Cause of Health Conditions: [ ] Injury [ ] Auto Accident [ ] Personal Injury [ ] Other: _____
   Has the accident been reported? Yes No Reported to: [ ]Employer [ ]Auto Carrier [ ]Other: _____
   Are you now or have you ever been disabled? Yes No Date: _____ Cause: _____
   Have you ever retained an attorney? Yes No Name: _____ Phone: _____

5. Pain Symptoms: a. _____ Began (Mo/Yr)_____ Previous Episodes (Mo/Yr)_____
   (In Order b._____ Began (Mo/Yr)_____ Previous Episodes (Mo/Yr)_____
   of Severity) c. _____ Began (Mo/Yr) _____ Previous Episodes (Mo/Yr)_____

6. Please indicate areas of pain or discomfort and mark them using the codes listed below:
   N=Numbness, T=Tingling, B=Burning, P=Pain, S=Soreness, A=Ache, SB=Stabbing, SF=Stiffness, X=Scars

   List the frequency and severity of your condition on a scale of 1 to 5:

| Frequency: | Severity: |
|---|---|
| 1=20% of the time | 1=Annoying |
| 2=40% of the time | 2=Impairment to Activity |
| 3=60% of the time | 3=Need Medication |
| 4=80% of the time | 4=Impairment with Medication |
| 5=100% of the time | 5=Severe (Need Hospitalization) |

| Location/Body Part | Frequency | Severity | Initial Cause | Getting Worse? |
|---|---|---|---|---|
| a. _____ | _____ | _____ | _____ | Yes No |
| b. _____ | _____ | _____ | _____ | Yes No |
| c. _____ | _____ | _____ | _____ | Yes No |

   Does it affect other areas of your body (please circle)? Yes No
   If yes, explain: _____

7. Do you have, or have you ever had:

| | | | |
|---|---|---|---|
| Osteoarthritis | Bone Spurs | Non-union Fracture | Ganglion or Baker's Cyst |
| Bulging Disc | Tendonitis | Avascular Necrosis | Cartilage injury |
| Herniated Disc | Joint Separations | Post-herpetic neuralgia | (Meniscus Tear, Chondromalacia |
| DDD | Bursitis | Intercostal Neuralgia | Patellar Syndrome) |
| Stenosis | Sprains | Morton's Neuroma | |

8. Does the condition interfere with (please check): Work Sleep Other: _____
   Please describe: _____
   Without treatment, how would it affect your quality of life? _____
   _____

9. What seems to make the condition better? _____
What seems to make it worse? _____
What treatments have you tried? _____

10. If you are currently under the care of a health care practitioner for any conditions or injuries, please provide their:
Name: _____ Phone: _____ Email: _____
Description of Treatment: _____

11. Please list any current therapies: _____

12. Please describe your lifestyle (please check):

Appetite: Low ☐ Moderate ☐ High ☐
Thirst for Water: ☐ Yes ☐ No _____ Glasses/Day
Coffee: ☐ Yes ☐ No _____ Cups/Day
Soda: ☐ Yes ☐ No _____ Cups/Day
Artificial Sweeteners: ☐ Yes ☐ No
Cravings for Sugar: ☐ Yes ☐ No
Cravings for Salty Foods: ☐ Yes ☐ No
Stress Level: ☐ High ☐ Moderate ☐ Low
Alcohol: ☐ Yes ☐ No _____ Glasses/Day
Smoking: ☐ Yes ☐ No _____ Cigarettes/Day
Marijuana: Yes No _____ Times/Day
Other Drugs : _____
Occupational Hazards: _____

Exercise (please check):

☐ None ☐ Very Active
☐ Light ☐ Elite Athlete
☐ Moderate
☐ Active

Type of Exercise: _____
Frequency of Exercise: _____

13. List vitamins or supplements taken in the last 2 months: _____

14. List prescribed and over-the-counter pharmaceutical medication taken in the last 2 months:
Anti-acids (please check): [ ] TUMS [ ] Zantac [ ] Other: _____
Proton Pump Inhibitors (please check): [ ] Prilosec [ ] Pepcid [ ] Prevacid [ ] Other: _____
Other Medications: _____

15. Please describe your health history (please check).

| Now | Past | | Now | Past | | Now | Past | | Now | Past | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | Acid Reflux/Heart Burn | ☐ | ☐ | Coronary artery disease | ☐ | ☐ | High Cholesterol | ☐ | ☐ | Rheumatic Fever |
| ☐ | ☐ | AIDS/HIV | ☐ | ☐ | Cystic Fibrosis | ☐ | ☐ | Hyperlipidemia | ☐ | ☐ | Rheumatoid Arthritis |
| ☐ | ☐ | Alcoholism | ☐ | ☐ | Diabetes | ☐ | ☐ | Influenza | ☐ | ☐ | Sarcoidosis |
| ☐ | ☐ | Allergies | ☐ | ☐ | Diverticulitis | ☐ | ☐ | IBD | ☐ | ☐ | Scoliosis |
| ☐ | ☐ | Anemia | ☐ | ☐ | Drug Withdrawal | ☐ | ☐ | IBS | ☐ | ☐ | Scarlet Fever |
| ☐ | ☐ | Appendicitis | ☐ | ☐ | Emphysema | ☐ | ☐ | Kidney Stones | ☐ | ☐ | Small intestinal bacterial overgrowth (SIBO) |
| ☐ | ☐ | Arthritis | ☐ | ☐ | Epilepsy | ☐ | ☐ | Kidney Failure | | | |
| ☐ | ☐ | Arteriosclerosis | ☐ | ☐ | Eczema | ☐ | ☐ | Lyme Disease | ☐ | ☐ | Seizures |
| ☐ | ☐ | Asthma | ☐ | ☐ | Erectile Dysfunction | ☐ | ☐ | Meniere's Disease | ☐ | ☐ | Stroke |
| ☐ | ☐ | Atrial Fibrillation | ☐ | ☐ | Fatty Liver | ☐ | ☐ | Mental Disorder | ☐ | ☐ | Thyroid Disorders |
| ☐ | ☐ | Birth Trauma | ☐ | ☐ | Fibromyalgia | ☐ | ☐ | Migraines | ☐ | ☐ | Tuberculosis |
| ☐ | ☐ | Bronchiectasis | ☐ | ☐ | Fibroid | ☐ | ☐ | Multiple Sclerosis | ☐ | ☐ | Typhoid Fever |
| ☐ | ☐ | Breast Lump | ☐ | ☐ | Gallbladder Stones | ☐ | ☐ | Ovarian Cyst | ☐ | ☐ | Ulcers, Location: _____ |
| ☐ | ☐ | Cancer | ☐ | ☐ | Goiter | ☐ | ☐ | Pacemaker | ☐ | ☐ | Ulcerative Colitis |
| ☐ | ☐ | Candida | ☐ | ☐ | Gout | ☐ | ☐ | Pancreatitis | ☐ | ☐ | Crohn's Disease |
| ☐ | ☐ | Chicken Pox | ☐ | ☐ | Hernia | ☐ | ☐ | Pleurisy | ☐ | ☐ | UTI |
| ☐ | ☐ | Chronic Bronchitis | ☐ | ☐ | Heart Murmur | ☐ | ☐ | Pneumonia | ☐ | ☐ | Interstitial Cystitis |
| ☐ | ☐ | Chronic kidney disease | ☐ | ☐ | Hepatitis | ☐ | ☐ | Prostatitis | ☐ | ☐ | Vitiligo |
| ☐ | ☐ | Cirrhosis | ☐ | ☐ | Herpes | ☐ | ☐ | Psoriatic arthritis | ☐ | ☐ | Venereal Disease |
| ☐ | ☐ | Congestive heart failure | ☐ | ☐ | High Blood Pressure | ☐ | ☐ | Psoriasis | ☐ | ☐ | Whooping Cough |
| ☐ | ☐ | COPD | | | | ☐ | ☐ | Pulmonary fibrosis | ☐ | ☐ | Other, Describe _____ |

16. Please use the point scales to rate your symptoms over the past 3 months.

**1 = Occasional, Not Severe 2 = Occasional, Severe 3 = Frequent, Not Severe 4 = Frequent, Severe**

| **Digestive Tract** | | | |
|---|---|---|---|
| ___Acid reflux/Heart burn | ___Bloating | ___Gluten Intolerance | ___Difficulty Swallowing |
| ___Poor Digestion | ___Gas | ___Food Allergies | ___Diarrhea |
| ___Nausea & Vomiting | ___Hiccups | ___Chemical Sensitivities | ___Constipation |
| | ___Bad Breath | ___Malnutrition | ___Laxative Use |

___Blood in Stool
___Mucous in Stool
___Black Stool
___Stomach Pains/Cramps
___Abdominal Pain
___Abdominal Spasms
___Lack of Bowel Control
___Itchy Anus
___Rectal Pain
___Hemorrhoids
___Anal Fissures
Bowel Movements: __
Frequency:_____
Texture/Form_____
Color_____
Odor _____

**General**
___Sweat Easily
___Night Sweats
___Gallbladder Trouble
___Cold Hands or Feet
___Poor Circulation
___Spitting Blood
___Fever
___Chills
___Muscle Cramps
___Lower Extremity Edema
___Vertigo or Dizziness
___Bleed or Bruise Easily
___Frequent Illness
___Seasonal Allergy
___Addicted to Drugs
___Addicted to Smoking
___Peculiar Taste:
Describe: _____

**Respiratory**
___Tight Chest
___Shortness of Breath
___Difficulty Breathing
When Lying Down
___Itching Inside the Chest
___Wheezing
___Persistent Cough
___Coughing Blood
___Cough: Wet / Dry, Thick / Thin
Color of Phlegm_____
___Other Lung Problems

**Urinary**
___Bedwetting
___Blood in Urine
___Lack of Bladder Control
___Pain During Urination
___Frequent/urgent urination
___Incomplete Urination
___Difficulty Urination
___Wake to Urinate
___ Prostate Problem
___ Genital Itch or Discharge
___ Premature Ejaculation
___ Recurrent Bladder Infections
___ Impotence
___ Increased Libido
___ Decreased Libido

**Weight & Eating**
___Recent Weight Loss
___Recent Weight Gain
___Binge Eating/Drinking
___Craving Certain Foods
Describe: _____
___Excessive Weight
___Loss of Taste
___Compulsive Eating
___Poor Appetite
___Heavy Appetite
___Strongly Like Cold Drinks
___Strongly Like Hot Drinks
___Water Retention

**Musculoskeletal**
___Muscle Pains
___Muscle Cramps
___Pains or Aches in Joints
___Stiffness/Limited Range of Motion
___Pains or Aches in Muscles
___Feeling of Weakness/Tiredness
___Swollen Tender Joints
___Pain in Legs
___Hip Tightness/Coldness/Pain
___Rib Pain
___Neck/Shoulder Pain
___Upper Back Pain
___Back Pain
___Lower Back Pain
___Sciatic Pain

**Cardiovascular**
___Heart Murmur
___Heart Palpitations
___Irregular or Skipping Heartbeat
___Rapid or Pounding Heartbeat
___Chest Pain
___Difficulty Breathing
___High Blood Pressure
___Low Blood Pressure
___Blood Clots
___Anemia
___Fainting
___Tachycardia

**Emotions**
___Mood Swings
___Anxious, Fear, Nervous
___Angry Irritable, Aggressive
___Easily Stressed
___Argumentative
___Frustrated, Cries Easily
___Depression
___Abuse Survivor
___Considered/Attempted Suicide
___Seeing a Therapist
___Obsessive Behavior
___Compulsive Thoughts
___Uncontrollable Urges

**Mind**
___Poor Memory
___Difficulty Completing Projects
___Difficulty with Mathematics
___Underachiever
___Poor/Short Attention Span
___Confusion
___Easily Distracted
___Difficulty Making Decisions
___Learning Disability

**Neurological**
___Seizures
___Numbness
___Tics
___Foot Neuropathy

**Energy & Activity**
___Apathy, Lethargy
___Attention Deficit
___Fatigue
___Lack of Strength
___Body Heaviness
___Hyperactivity
___Restlessness
___Shortness of Breath
___Stuttering or Stammering
___Slurred Speech

**Ears**
___Itchy Ears
___Ear Aches, Ear Infections
___Drainage from Ears
___Hearing Loss
___Reddening of the Ears
___Ringing in the Ears
___Headaches
___Concussions

**Nose**
___Stuffy Nose
___Dryness Inside the Nose
___Chronically Red,
Inflamed Nose
___Sinus Problem
___Hay Fever
___Sneezing Attacks
___Excessive Mucous Formation
___Back Dripping
___Nose Bleeding

**Eyes**
___Glasses/Contacts
___Watery or Itchy Eyes
___Red, Swollen or Sticky Eyelids
___Bags/Dark Circles Under Eyes
___Poor Vision
___Blurred or Tunnel Vision
___Sensitive to Sunlight
___Eye Strain
___Eye Pain
___Red Eyes
___Itchy Eyes
___Easily Fatigued Eyes
___Spots in Eyes
___Night Blindness
___Glaucoma
___Cataract

**Head**
___Headaches
___Migraines
___Faintness
___Dizziness
___Facial Flushing
___Facial Pain
___TMJ

**Sleep**
___Insomnia
___Sleep Disorder
___Difficulty Falling Asleep
___Difficulty Staying Asleep
___Wakes Up Frequently
___Morning Shakiness
___Cannot Wake Up in Morning

**Mouth & Throat**
___Chronic Coughing
___Gagging, Often Clearing Throat
___Sore Throat, Hoarse, Voice Loss
___Swollen/Discolored Tongue/Lips
___Sores on Lips or Tongue
___Canker Sores
___Itching on Roof of Mouth
___Dry Mouth
___Excessive Saliva
___Recurrent Sore Throat
___Excessive Phlegm
Color: _____
___Swollen Glands
___Lumps in Throat
___Enlarged Thyroid
___Teeth Problem
___Gum Problem
___Grinding Teeth

**Skin & Hair**
___Acne
___Itching
___Hives
___Rash
___Eczema
___Dry Skin
___Ulcerations
___Hair Loss
___Dandruff
___Flushing or Hot Flashes
___Change in Hair/Skin Texture
___Loss in Pigmentation
___Skin Fungal Infections

**For Women Only**
Age Menstrual Cycle Began:
_____
Length of Cycle (Day 1 - Day 1):
_____
Duration of Flow: _____
___Dark Color Flow
___Clots in Flow
___Excessive Flow
___Irregular Cycle
___Painful Period
___Painful Intercourse
___Excessive Vaginal Discharge
___Menopause Symptoms
___Lump in Breast
___Vaginal Dryness
___Vaginal Sores
___Vaginal Odor
Vaginal Discharge Color:
_____
# of Pregnancies: _____
# of Live Births: _____
# of Premature Births: ____
Age at Menopause: _____
Date Last Period Began:
_____

**Any Other Symptoms:**
_____
_____

17. Operations and Procedures

| **Date** | **Date** | **Date** | |
|---|---|---|---|
| _____Vaccinations | _____Tubes in Ears | _____ Sinus | **Other:** _____ |
| _____ Tonsillectomy | _____ Appendectomy | _____ Hernia | **Date:** _____ |
| _____Gallbladder | _____ Gynecological | _____ Thyroid | |
| _____Back Operation | _____Rectal Surgery | _____ Stomach | |

List and date any accidents or falls (please check):
[ ] Car _____, [ ] Recreation _____, [ ] Sports _____, [ ] School _____, [ ] Other _____
List any broken bones: _____
Have you ever had spinal taps or spinal injections (please check)? ☐ Yes ☐ No Date: _____
Have you ever lost consciousness (please check)? ☐ Yes ☐ No Why? _____
Have you ever had X-ray taken? ☐ Yes ☐ No Date: _____ By Whom? _____
For what ailment were these X-rays taken? _____
Do you suffer from any condition other than that for which you are now consulting us? _____

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I understand and agree that health and accident insurance policies are an arrangement between the insurance company and me. The heath care provider's office will prepare necessary paperwork to assist me in the filling insurance claims but cannot guarantee reimbursement. Direct payments made from the insurance company to the health care provider's office will be credited to my account upon receipt and any balances due will be my responsibility. All services rendered to me are my personal responsibility and I agree to make payments for these services to the health care provider's office. I also understand that if I suspend or terminate my care and treatment, any fees for services rendered will be immediately due and payable. Should third party collection become necessary, I agree to pay all fees involved in collections of the account.

I authorize the health care provider to examine and treat my condition as deemed appropriate through the use of chiropractic care, acupuncture, Traditional Chinese Medicine, and/or other natural healing methods.

**Patient's / Guardian's Signature: _____ Date: _____**