

**CHIROPRACTIC FIRST - HEALTH HISTORY FORM**

Patient's Name \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**\*\*\*If you are NOT experiencing ANY symptoms, please go to Section B: Health History\*\*\***

**Section A: Current Problem** Please answer the following questions regarding your **current** problem:

Please mark on the picture, where you have any problems.

Date of Onset: \_\_\_\_\_ Cause of Condition (if known) \_\_\_\_\_

How often during the day do you experience this?

0-25%    25-50%    50-75%    75-100%

Describe the pain: sharp    dull    achy    stiff    shooting    burning    spasm

How severe is this problem? No Pain 1 2 3 4 5 6 7 8 9 10 Extreme

Since the onset, is the pain? worse    better    same    on & off

Is there anything that makes it worse? standing    sitting    lying down    motion

Is there anything that makes it better? standing    sitting    lying down    motion

Is this problem? Better or Worse    AM or PM    Neither

Are any systems involved? Digestive    Cardiovascular    Respiratory    Elimination    Reproductive

Does the pain cause you to? Lose sleep    Be short tempered    Miss work    Miss play    Lose focus

What has this problem kept you from enjoying? \_\_\_\_\_

Have you had a similar condition in the past? Y N If yes, explain: \_\_\_\_\_

What treatment(s) have you already had for this problem?

Medication    Surgery    Physical Therapy    Chiropractic    None    Other: \_\_\_\_\_

What was the outcome of this treatment? \_\_\_\_\_

Any other facts about your current problem or pain: \_\_\_\_\_

Is there any chance you could be pregnant? YES NO Date of last menstrual period: \_\_\_\_\_

**Section B: Health History** (Please ✓ if you have had or are currently experiencing any of the following:)

- Anxiety    Anemia    Arthritis    Thyroid Problems    Bowel Problems
- Cancer    HIV/AIDS    Tuberculosis    High Blood Pressure    Heart Trouble
- Diabetes    Hepatitis    Insomnia    Venereal Disease    Muscular Dystrophy
- Epilepsy    Dizziness    Convulsions    Multiple Sclerosis    Rheumatic Fever
- Neuritis    Asthma    Scarlet Fever    Digestive Problems    Sinus Trouble
- Allergies    Backaches    Numbness    Frequent Colds    Nervousness
- Stroke    Depression    Headaches    Cold Hands/Feet    Restless Sleep
- Ulcer Irritability    Impulsivity    Low Pain Threshold Fibromyalgia
- Hernia    PMS    Bruising    German Measles    Osteoporosis
- Nausea    Swelling    Mood Swings    Chronic Fatigue Syndrome    Infertility

Describe other details about YOUR Past Medical History: \_\_\_\_\_

**Section C: Family History** (Your Blood Relatives Only)

- Diabetes    Heart Disease    Cancer    Thyroid Problems    Stroke    Multiple Sclerosis
- Other: \_\_\_\_\_

