



**Additional History:**

Have you ever had Chiropractic care before? __ Yes __ No
If “yes”, for what condition?
Was the treatment effective?
What type of services do you desire? (Check one) Temporary Relief _____ Increased Vitality (Health, Longevity, Energy, and Productivity)
Do you currently take prescription medication? __ Yes __ No
Do you take over-the-counter medication? __ Yes __ No
Do you currently take any vitamins, supplements, herbs, and/or homeopathy? __ Yes __ No
Any previous surgical procedure(s)? __ Yes __ No If “yes” please explain:

**Current & Past Health History**

**Head, Neck, Back, Extremities — Check those appropriate to you**

**Head**

- Headache
- Migraine
- “Sinus” Headaches
- Dizziness
- Light Headache
- Hearing Loss
- Ringing in Ears

**Neck**

- Pain
- Stiffness
- Weakness
- Grinding
- “Pinched” Nerve
- Feels Out of Place

**Arms & Hands**

- Pain  Left  Right
- Weakness  Left  Right
- Numbness/ Tingling  Left  Right
- “Pins & Needles”  Left  Right
- Cold Hands  Left  Right

**Shoulders**

- Pain Across Shoulders
- Pain in Shoulder Joint
- Pain with Movement
- Difficulty Raising Arm
- “Pinched” Nerve
- Grinding/Popping

**Mid & Upper Back**

- Pain
- Stiffness
- Tension
- Muscle Spasm
- “Pinched” Nerve

**Low Back**

- Pain
- Stiffness
- Weakness
- “Pinched” Nerve
- Feels Out of Place

Pain Worse with:

- Sitting
- Standing
- Bending
- Twisting
- Stooping
- Lifting
- Coughing

**Hips, Legs, & Feet**

- Pain in Buttock/Hip  Left  Right
- Pain in Knee  Left  Right
- Pain in Ankle  Left  Right
- Numbness/Tingling-Thigh  Left  Right
- Numbness/Tingling-Leg  Left  Right
- Weakness  Left  Right
- “Pins & Needles”  Left  Right
- Cold Feet  Left  Right

## Current & Past Health History Continued

### Medical History

- |   |   |
|---|---|
| <input type="checkbox"/> AIDS/HIV         | <input type="checkbox"/> Heart Attack       |
| <input type="checkbox"/> Alcoholism       | <input type="checkbox"/> Heart Disease      |
| <input type="checkbox"/> Anemia           | <input type="checkbox"/> Hepatitis          |
| <input type="checkbox"/> Aneurysm         | <input type="checkbox"/> Kidney Disease     |
| <input type="checkbox"/> Atherosclerosis  | <input type="checkbox"/> Liver Disease      |
| <input type="checkbox"/> Arthritis        | <input type="checkbox"/> Measles            |
| <input type="checkbox"/> Ankylosing Spond | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Osteo A.         | <input type="checkbox"/> Mumps              |
| <input type="checkbox"/> Rheumatic A.     | <input type="checkbox"/> Osteoporosis       |
| <input type="checkbox"/> Asthma           | <input type="checkbox"/> Pacemaker          |
| <input type="checkbox"/> Cancer           | <input type="checkbox"/> Pneumonia          |
| <input type="checkbox"/> Chataracts       | <input type="checkbox"/> Polio              |
| <input type="checkbox"/> Chicken Pox      | <input type="checkbox"/> Prostrate Problems |
| <input type="checkbox"/> Diabetes         | <input type="checkbox"/> Prosthesis         |
| <input type="checkbox"/> Childhood Onset  | <input type="checkbox"/> Rheumatic Fever    |
| <input type="checkbox"/> Adult Onset      | <input type="checkbox"/> Scarlet Fever      |
| <input type="checkbox"/> Drug Dependency  | <input type="checkbox"/> Stroke             |
| <input type="checkbox"/> Epilepsy         | <input type="checkbox"/> Tuberculosis       |
| <input type="checkbox"/> Fracture         | <input type="checkbox"/> Tumors             |

### Cardiovascular

- Chest Pain
- Cold Hands or Feet
- High Blood Pressure
- High Cholesterol
- Irregular Heart Beat
- Low Blood Pressure
- Rapid Heart Beat
- Swelling of Ankles
- Other: \_\_\_\_\_

### Skin & Nails

- Blue or Purple Skin
- Blue or Purple
- Nailbeds
- Ridged Nails
- Mole Changes
- Non-Healing Sores
- Slow Wound Healing
- Yellow Skin

### General Symptoms

- Coughing up Blood
- Depressed
- Fainting Spells
- Fatigue
- Loss of Balance
- Loss of Coordination
- Loss of Sleep
- Muscle Weakness
- Shortness of Breath
- Weight Loss

### Gastrointestinal

- Excessive Thirst
- Bloating
- Feeling of "Fullness"
- Indigestion
- Stomach Pain
- Nausea
- Vomiting
- Diarrhea
- Bloody Stool
- Black, tarry stool
- Hemorrhoids
- Colitis
- Other: \_\_\_\_\_

### Eye, Ear, Nose & Throat

- Blurred Vision
- Double Vision
- Visual Disturbance
- Hearing Loss
- Ringing in Ears
- Nose Bleeds
- Bleeding Gums
- Difficulty Swallowing
- Persistent Cough

### Social History

- Smoke \_\_\_\_\_
- Other Tobacco \_\_\_\_\_
- Alcohol \_\_\_\_\_
- Family Stress \_\_\_\_\_
- Work Stress \_\_\_\_\_
- Crave Salt \_\_\_\_\_
- Crave Sweets \_\_\_\_\_
- Balanced Diet \_\_\_\_\_
- Sufficient Rest \_\_\_\_\_
- Exercise \_\_\_\_\_

### Genitourinary

- Frequent Urination
- Pain with Urination
- Incontinence

### Women Only

- |  |  |  |
|--|--|--|
| Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No | Date of Last OB/GYN exam: _____                                | <input type="checkbox"/> Bleeding Between Periods    |
| Type of Birth Control: _____   | <input type="checkbox"/> Abnormal Pap Smear                    | <input type="checkbox"/> Heavy or Prolonged Bleeding |
| Date of Last Period: _____   | <input type="checkbox"/> Severe Menstrual Pain                 | <input type="checkbox"/> Breast Lump(s)              |
| <input type="checkbox"/> Breast Augmentation                               | <input type="checkbox"/> Cancer <input type="checkbox"/> Cysts | <input type="checkbox"/> Other: _____                |

I, the undersigned, certify that the above information is correct to the best of my knowledge and am solely responsible for any incorrect information I may have given or omissions I may have made.

Responsible Party's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I authorize treatment for my minor child as deemed necessary by my doctor.

Responsible Party's Signature: \_\_\_\_\_ Date: \_\_\_\_\_