Health History

Patient Name_____ Date_____

Height_____ Weight_____ Date of Birth_____

Have you ever seen a chiropractor?_____ Please describe **WHY YOU ARE SEEKING CARE**

_____

SYMPTOMS

What do you feel and where do you feel it	How long have you been aware of it	What makes it better	What makes it worse

MEDICATIONS what and why

Do you have any history of **TRAUMA**? _____

Please list any surgeries/accidents/fractures (Include Complications of Pregnancy)

Date	Occurrence

Do you or have you had pain in any these areas? If yes, when?		**Do you, or have you had any of the following Conditions?**			
x	Date	x	Date	x	Date
	Neck:		Alcoholism:		Incontinence:
	Shoulder:		Asthma:		Insomnia:
	Arm:		Arthritis:		Kidney Prob:
	Elbow:		Bipolar:		Mental Illness:
	Wrist:		Cancer:		Numbness:
	Hand:		Diabetes:		Where?
	Upper Back:		Dizziness/Fainting:		Pain at Night:
	Chest:		Epilepsy:		Prostatitis:
	Middle Back:		Fibromyalgia:		Ringing in Ears:
	Low Back:		Gallstones:		Short of Breath:
	Hip:		Headache		Stomach Ulcer:
	Pelvis:		Heart Disease:		Stroke:
	Leg:		Hepatitis:		Thyroid Disease:
	Knee:		Herpes:		Tuberculosis:
	Ankle:		HIV/AIDS:		Uro-Genital Prob:
	Foot:		Impaired Vision:		Other:
	Other:				