

6. PAST HEALTH HISTORY

PATIENT NAME: _____

Do you have any of the following? Please check YES or NO for each condition.

Relative Contraindications:

- Articular Hypermobility Disease Yes No
- Severe Demineralization of Bone Yes No
- Benign Bone Tumor (Spine) Yes No
- Bleeding Disorder Yes No
- Are You Taking Anticoagulants Therapy Yes No

Absolute Contraindications:

- Rheumatoid Arthritis Yes No
- Ankylosing Spondylitis Yes No
- Fracture(s) _____ Yes No
- Dislocation(s) _____ Yes No
- Unstable OS Odontoidum Yes No

Radiculopathy with Progressive Neurological Signs,

- Radiating Pain, Numbness or Weakness into:
- Upper Extremities Yes No
 - Lower Extremities Yes No
- Malignancies Yes No
- Infection of bones or joints of the vertebral column Yes No
- Myelopathy Yes No
- Cauda Equina Syndrome Yes No
- Vertebrobasilar Insufficiency Syndrome Yes No
- Major Artery Aneurysm Yes No

Previous Major Illnesses and Injuries _____

Operations, Hospitalizations, Surgeries _____

Medications you are currently taking: None

- High Blood Pressure _____ Cholesterol _____ Pain _____ Arthritis _____
- Depression _____ Anxiety _____ ADD/ADHD _____ Insulin _____
- Other _____

Allergies

FAMILY HISTORY - Immediate Family Members (Father, Mother, Brother, Sister)

Supplements

Health status of family members: _____

Are there any family members that suffer from:

- Stroke Heart Disease Cancer Tumor Degenerative Disc Disease Arthritis Osteoporosis
- Other _____

If any of the above items are checked, then whom in your family suffers? _____

Are there any diseases that are "hereditary" or seem to run in your family?

SOCIAL HISTORY - Please answer the following:

Please tell the Doctor about your activities:

- Exercise: **Work / School:** None **Habits:** None **Education:**
- None Sitting Smoking - Packs Per Day _____ None High School
 - Occasional Standing Alcohol - Times Per Week _____ None Some College
 - Daily Light Labor Caffeine: Coffee, Tea, Sodas... _____ None College Grad
 - Weekly Heavy Labor **Hobbies** _____ None Post Grad
 - Other Computer

I certify the information on these forms are true to the best of my knowledge, and hereby authorize this office of chiropractic to provide me with chiropractic and therapeutic care for my condition if I am accepted as a patient.

Patient Signature _____

Date ____/____/____

Doctor's Signature _____

Date ____/____/____

SYMPTOM(S) QUESTIONNAIRE

Patient Name _____ Initial Visit Subsequent Visit

Please tell us about your symptoms: _____

My pain / symptom(s) are getting: Better Worse About the same Other

Please use the key to mark the diagram

Pain / Discomfort Scale: (please Circle) Least 0 1 2 3 4 5 6 7 8 9 10+ Worst

A = Ache

N = Numbness

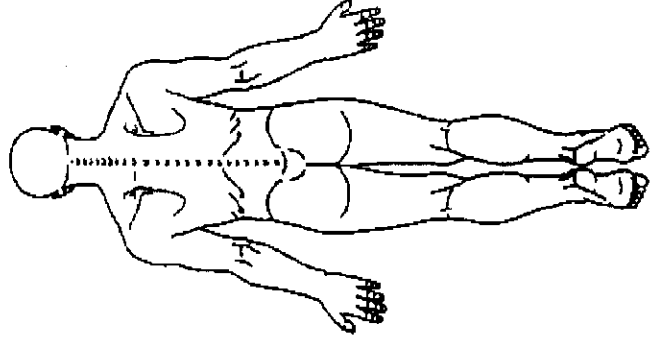
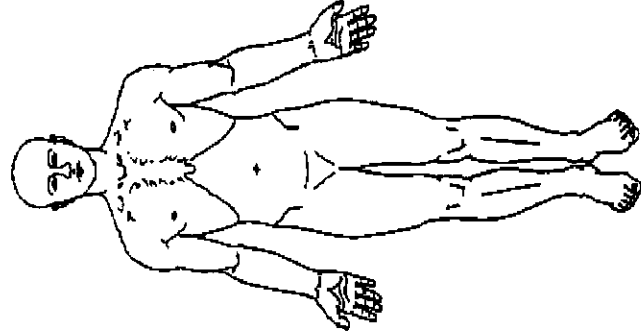
S = Stiff

SR = Sore

T = Tingle

P = Pain

P&N = Pins & Needles



Please tell us how your symptoms are affecting your activities

HOME

Sleeping No Affect Mild Affect Moderate Affect Severe Affect

Self Care

Household Chores

Yard Work

Enjoyment

Productivity

WORK

Concentration No Affect Mild Affect Moderate Affect Severe Affect

Duties, Activities

Mood

Travel

Enjoyment

Productivity

OTHER ACTIVITIES

Sit, Stand, Walk No Affect Mild Affect Moderate Affect Severe Affect

Raising from Chair

Bend, Lift, Twist

Turn Head

Hobbies, Exercise, Sports

Enjoyment

Patient Signature _____

Date ____/____/____

Doctor Signature _____

Date ____/____/____

Patient _____

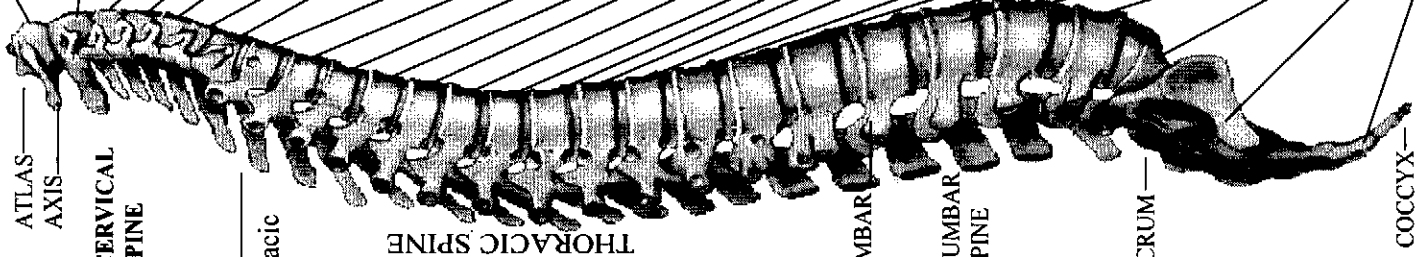
Date _____

REVIEW OF SYSTEMS:

- Gastro Intestinal Genitourinary Musculoskeletal Neurological Constitutional Eyes ENMT Cardiovascular Respiratory
- Integumentary Psychiatric Endocrine Hematologic Immunologic All Others Negative

Instructions: Please mark ALL you have suffered with now or in the past.

Vertebrae



Area Controlled *

Possible Effects of Malfunction

1C Blood supply to the head, pituitary gland, scalp, bones of the face, brain, inner and middle ear, sympathetic nervous system.	<input type="checkbox"/> Headaches <input type="checkbox"/> Migraine Headaches <input type="checkbox"/> Head Colds <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Chronic Tiredness <input type="checkbox"/> Amnesia <input type="checkbox"/> ADD/ADHD <input type="checkbox"/> Nervousness <input type="checkbox"/> Insomnia <input type="checkbox"/> Dizziness
2C Eyes, optic nerves, auditory nerves, sinuses, mastoid bones, tongue, forehead.	<input type="checkbox"/> Sinus Trouble <input type="checkbox"/> Allergies <input type="checkbox"/> Pain Around the Eyes <input type="checkbox"/> Earaches <input type="checkbox"/> Crossed Eyes <input type="checkbox"/> Blindness (some) <input type="checkbox"/> Deafness <input type="checkbox"/> Fainting
3C Cheeks, outer ear, face bones, teeth, trifacial nerve.	<input type="checkbox"/> Neuralgia <input type="checkbox"/> Neuritis <input type="checkbox"/> Acne / Pimples <input type="checkbox"/> Eczema <input type="checkbox"/> Neck Pain, Stiffness, Soreness
4C Nose, lips, mouth, Eustachian tube.	<input type="checkbox"/> Hay Fever <input type="checkbox"/> Runny Nose <input type="checkbox"/> Swollen Adnoids
5C Vocal Cords, neck glands, pharynx.	<input type="checkbox"/> Laryngitis <input type="checkbox"/> Hoarseness <input type="checkbox"/> Hand/Finger Numbness <input type="checkbox"/> Sore Throats <input type="checkbox"/> Tonsillitis
6C Neck muscles, shoulders, tonsils.	<input type="checkbox"/> Stiff Neck <input type="checkbox"/> Pain in Upper Arm <input type="checkbox"/> Chronic Cough <input type="checkbox"/> Croup <input type="checkbox"/> Hand/Finger Numbness <input type="checkbox"/> Shoulder Pain
7C Thyroid Gland, bursae in the shoulders, elbows.	<input type="checkbox"/> Bursitis <input type="checkbox"/> Colds <input type="checkbox"/> Thyroid Conditions <input type="checkbox"/> Wrist, Hand / Finger Pain or Numbness
1T Arms from the elbows down, including hands, wrists, and fingers, esophagus and trachea.	<input type="checkbox"/> Asthma <input type="checkbox"/> Cough <input type="checkbox"/> Difficulty Breathing <input type="checkbox"/> Pain into Arms or Hands <input type="checkbox"/> Shortness of Breath
2T Heart, including its valves and covering, coronary arteries.	<input type="checkbox"/> Heart Problems <input type="checkbox"/> Chest Pain <input type="checkbox"/> High Blood Pressure
3T Lungs bronchial tubes, pleura, chest, breast.	<input type="checkbox"/> Bronchitis <input type="checkbox"/> Pleurisy <input type="checkbox"/> Pneumonia <input type="checkbox"/> Congestion <input type="checkbox"/> Influenza <input type="checkbox"/> Mid Back Pain, Burning, Stiffness, Soreness
4T Gallbladder, common duct	<input type="checkbox"/> Gallbladder Conditions <input type="checkbox"/> Jaundice <input type="checkbox"/> Shingles
5T Liver, solar plexus, circulation-general	<input type="checkbox"/> Liver Conditions <input type="checkbox"/> Fevers <input type="checkbox"/> Arthritis <input type="checkbox"/> Poor Circulation <input type="checkbox"/> Other Blood Pressure Problems
6T Stomach.	<input type="checkbox"/> Stomach Troubles <input type="checkbox"/> Nervous Stomach <input type="checkbox"/> Indigestion <input type="checkbox"/> Heartburn <input type="checkbox"/> Dyspepsia <input type="checkbox"/> Nausea
7T Pancreas, duodenum.	<input type="checkbox"/> Ulcers <input type="checkbox"/> Gastritis <input type="checkbox"/> Mid Back Pain or Burning
8T Spleen	<input type="checkbox"/> Lowered Immune System
9T Adrenal and Suprarenal glands	<input type="checkbox"/> Allergies <input type="checkbox"/> Hives <input type="checkbox"/> Mid Back Soreness
10T Kidneys	<input type="checkbox"/> Kidney Problems <input type="checkbox"/> Pyelitis <input type="checkbox"/> Hardening of the Arteries <input type="checkbox"/> Chronic Tiredness <input type="checkbox"/> Nephritis <input type="checkbox"/> Back Pain
11T Kidneys, ureters	<input type="checkbox"/> Skin Conditions <input type="checkbox"/> Pimples <input type="checkbox"/> Boils <input type="checkbox"/> Acne <input type="checkbox"/> Eczema
12T Small intestines, lymph circulation	<input type="checkbox"/> Rheumatism <input type="checkbox"/> Gas Pains <input type="checkbox"/> Certain Types of Sterility
1L Large intestines, inguinal rings	<input type="checkbox"/> Constipation <input type="checkbox"/> Colitis <input type="checkbox"/> Dysentery <input type="checkbox"/> Diarrhea <input type="checkbox"/> Some Hernias <input type="checkbox"/> Back Pain
2L Appendix, abdomen, upper leg	<input type="checkbox"/> Cramps <input type="checkbox"/> Difficulty Breathing <input type="checkbox"/> Minor Varicose Veins
3L Sex organs, uterus, bladder, knees	<input type="checkbox"/> Bladder Problems <input type="checkbox"/> Painful or Irregular Periods <input type="checkbox"/> Miscarriages <input type="checkbox"/> Bed Wetting <input type="checkbox"/> Impotency <input type="checkbox"/> Change of Life Symptoms <input type="checkbox"/> Knee Pains
4L Prostate gland, muscles of the lower back, sciatic nerve	<input type="checkbox"/> Sciatica <input type="checkbox"/> Difficult, Painful, or Too Frequent Urination
5L Lower legs, ankles, feet	<input type="checkbox"/> Backaches <input type="checkbox"/> Pain, Burning or Numbness in Legs <input type="checkbox"/> Weak Ankles and Arches <input type="checkbox"/> Cold Feet <input type="checkbox"/> Swollen Ankles <input type="checkbox"/> Plantar Fasciitis <input type="checkbox"/> Foot Pain <input type="checkbox"/> Weakness in Legs <input type="checkbox"/> Leg Cramps <input type="checkbox"/> Heel Spurs <input type="checkbox"/> Poor Circulation in Legs
Sacrum	<input type="checkbox"/> Lower Back Pain into the Hip or Legs <input type="checkbox"/> Spinal Curvature
Coccyx	<input type="checkbox"/> Pain in Tailbone with Sitting <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Pruritis

*Directly or indirectly controlled.

Patient Signature _____

Doctor's Signature _____