

HEALTH HISTORY

Today's date _____ Birthdate _____ Age _____ Height _____ Weight _____
 Name _____ Sex: Male Female Number of children _____
 Address _____ Marital Status: Single Married Divorced Widowed
 City/State/Zip _____ Occupation _____
 Phone (home) _____ Employer _____
 Phone (work) _____ Do you have insurance? Yes No Will have soon
 Phone (cell) _____ Insurance Company _____
 E-mail (Optional) _____ Social Security Number (Required) _____

Please check how you heard about our office:
 Referral _____ Website / Internet _____ Walk-In / Drive-By _____ Yellow Pages Online / Book _____

Please check which services you would like to receive:
 Whatever is recommended Acupuncture Personal Training
 Chiropractic Rehabilitation Nutritional Consultation

Please check your current symptoms:
 Jaw / TMJ pain (R / L) Arm tingling / numbness (R / L) Radiating pain to hip / leg (R / L) Muscle spasms / soreness
 Headache (R / L) Elbow pain (R / L) Hip / leg pain (R / L) Anxiety / depression
 Neck pain (R / L) Wrist pain (R / L) Leg tingling / numbness (R / L) Dizziness / fainting
 Mid back pain (R / L) Hand pain (R / L) Knee pain (R / L) Fatigue
 Radiating pain to head (R / L) Hand tingling / numbness (R / L) Ankle pain (R / L) Ringing / buzzing in the ears
 Radiating pain to shoulder / arm (R / L) Low back pain (R / L) Foot pain (R / L) Visual disturbances
 Shoulder / arm pain (R / L) Sacroiliac pain (R / L) Foot tingling / numbness (R / L) Other _____

Of the above symptoms, which one is your main concern? _____
 When did you first notice this problem? _____
 Was it caused by: Auto accident On-the-job injury Other _____
 Describe _____

Have you been treated for this condition? Yes No
 If yes, when? _____ For how long? _____
 By whom? _____ Results? _____

Have you ever been treated by a Chiropractic Doctor? Yes No
 If yes, whom? _____ When? _____
 Results and impressions? _____

Have you ever been treated by an Acupuncturist? Yes No
 If yes, whom? _____ When? _____
 Results and impressions? _____

Are you currently being treated by any other Doctor(s)? Yes No
 If yes, whom? _____ Why? _____

Are you currently taking any over-the-counter or prescription medication? Yes No
 If yes, what and why? _____

Major Hospitalizations, Surgeries, Injuries: Please list all procedures, complications (if any) and dates:

Year	Surgery, Illness, Injury	Outcome
_____	_____	_____
_____	_____	_____
_____	_____	_____

HEALTH HISTORY

Review Of Systems

- Problems losing weight
- Problems gaining weight
- Skin problems
- Eyes/Ears/Nose/Throat problems
- Cardiovascular problems
- Respiratory problems
- Gastrointestinal problems
- Genitourinary problems
- Musculoskeletal problems
- Neurologic/Psychiatric problems
- Allergic problems
- Immune system problems
- Lymphatic problems
- Endocrine problems

Health History

- Allergies
- Asthma
- Blood clots
- Blood pressure, high
- Blood pressure, low
- Broken bones
- Cancer
- Cholesterol, high
- Chronic Fatigue Syndrome
- Colitis
- Diabetes
- Disc problems
- Diverticulitis
- Epilepsy
- Fibromyalgia
- Gastroesophageal reflux disease
- Gout
- Headache, cluster
- Headache, migraine
- Headache, sinus pressure
- Headache, stress/tension
- Heart attack
- Heart disease
- Hepatitis
- HIV positive / AIDS
- Infertility
- Irritable bowel syndrome (IBS)
- Obesity
- Osteoarthritis
- Osteoporosis
- Rheumatoid arthritis
- Sinus pressure/congestion
- Stroke
- Thyroid trouble, hyperthyroid
- Thyroid trouble, hypothyroid
- Ulcer
- Urinary tract infection (UTI)
- Varicose veins
- Water retention
- Other _____

Health History (Men only)

- Benign prostatic hyperplasia (BPH)
- Decreased testosterone level
- Difficult urination
- Prostate problems
- Testicular pain
- Other _____

Health History (Women only)

- Breast cancer
- Currently pregnant
- Endometriosis
- Fibrocystic breasts
- Fibroids / ovarian cysts
- Hysterectomy
- Menopause
- Menstrual irregularities
- Oral contraceptive use (current)
- Oral contraceptive use (past)
- Pre-menstrual syndrome (PMS)
- Vaginal infections
- Pregnancy, how many _____
- Childbirth, how many _____
- C-section, how many _____
- Stillbirth, how many _____
- Miscarriage, how many _____
- Abortion, how many _____
- Other _____

Family History (Parents and Siblings)

- Blood pressure, high
- Cancer
- Cholesterol, high
- Chronic Fatigue Syndrome
- Diabetes
- Eating disorder
- Epilepsy
- Fibromyalgia
- Headache, cluster
- Headache, migraine
- Headache, sinus pressure
- Headache, stress/tension
- Heart attack
- Infertility
- Irritable bowel syndrome (IBS)
- Mental illness
- Obesity
- Osteoarthritis
- Osteoporosis
- Rheumatoid arthritis
- Stroke
- Thyroid trouble, hyperthyroid
- Thyroid trouble, hypothyroid
- Other _____

Psychosocial History

- Alcoholism
- Anxiety disorders
- Decreased sex drive
- Depression
- Drug addiction
- Eating disorder
- Insomnia
- Mental illness
- Panic attacks
- Sexually transmitted disease
- Stress-induced eating
- Stress-induced not-eating

Overall Stress Level (1 being the lowest)

1 2 3 4 5 6 7 8 9 10

Major Causes of Stress

- Health
- Weight
- Work
- Family
- Finances
- Legal

Sleep Habits

- Less than 7 hours per night
- 7-9 hours per night
- More than 9 hours per night
- Sleep on stomach
- Sleep on side
- Sleep on back
- Difficulty staying asleep
- Difficulty falling asleep

Caffeine (Coffee, tea, soda)

- None
- Drink caffeine, but not on a daily basis
- 1 drink per day
- 2 drinks per day
- More than 2 drinks per day

Smoking

- None
- Smoke, but not on a daily basis
- Less than 1 pack per day
- 1 pack per day
- 2 packs per day
- More than 2 packs per day

Alcohol

- None
- Drink alcohol, but not on a daily basis
- 1 drink per day
- 2 drinks per day
- More than 2 drinks per day

Exercise

- None
- 1 2 3 4 5 6 7 days per week
- Stretching
- Yoga / Pilates
- Walking
- Aerobics
- Bicycling
- Running
- Swimming
- Weightlifting
- Other _____
- Gym membership? Yes No
- If so, where? _____

Nutrition

- No particular diet
- Vegetarian diet
- Low-sodium diet
- Low-fat diet
- Low-carbohydrate diet
- Low-glycemic diet
- Other _____

Food Allergies

- Dairy
- Eggs
- Wheat
- All gluten
- Soy
- Corn
- Other _____

Eating Habits

- Skip breakfast
- 1 meal per day
- 2 meals per day
- 3 meals per day
- 4 meals per day
- 5 meals per day
- Add salt to food

Water Intake (Not soda)

- None
- Less than 1 liter per day
- 1 liter per day
- 2 liters per day
- More than 2 liters per day

Current Supplements

- Multi-vitamin/mineral
- Omega-3 essential fatty acids (Fish oil)
- Vitamin E
- Calcium
- Magnesium
- Zinc
- Other _____

Signature of patient or legal guardian _____

Date _____

Clinic Representative _____