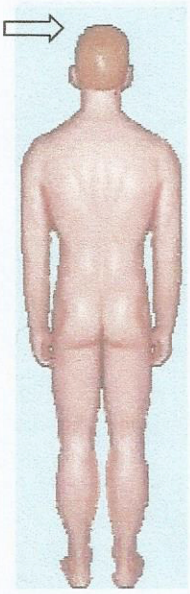
Health History

Patient name _____ Date _____

Chief Complaints: What is the reason for your visit today? List details below and mark on the drawing .

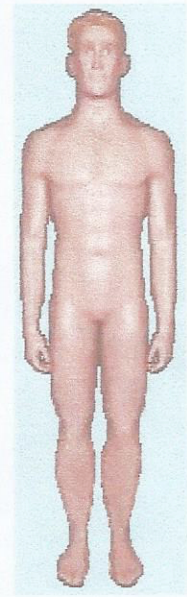


_____
_____
_____
_____
_____
_____

Activities of Daily Living

How does you condition currently interfere with your life and ability to function?
Please put a check mark in one of the four column as it applies to you.

	no effect	mild effect	moderate effect	severe effect
walking				
standing				
sitting				
bending				
stairs				
lifting/carrying				
driving				
exercise/sports				
sleeping				
concentration				
memory				
hearing				
seeing/visual				



Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body.

Review of Systems:

General Health
[ ] good general health
[ ] recent weight change
[ ] loss of appetite
[ ] fatigue

Allergies
[ ] drug allergies
[ ] food allergies
[ ] environmental allergies

Ears, nose, mouth, throat
[ ] difficult swallowing
[ ] earaches
[ ] loss of hearing
[ ] ringing in the ears
[ ] sinus infections
[ ] sore throats

Eyes
[ ] blind spots
[ ] blurred vision
[ ] double vision
[ ] glaucoma

GI
[ ] blood in stool
[ ] constipation
[ ] nausea
[ ] diarrhea
[ ] stomach or abdominal pains
[ ] ulcers
[ ] vomiting

Genitourinary
[ ] blood in urine
[ ] irregular or painful periods
[ ] miscarriages
[ ] kidney stones
[ ] prostate problems
[ ] painful or burning urination
[ ] sexual difficulties
[ ] incontinence

Heart and Lungs
[ ] chest pains
[ ] high blood pressure
[ ] irregular heart rate
[ ] high cholesterol

Muscles, joints, bones
[ ] back pain
[ ] difficult walking
[ ] joint pain
[ ] muscle pain
[ ] neck pain

Neurological
[ ] balance problems
[ ] blackouts
[ ] headaches
[ ] memory loss
[ ] mental confusion
[ ] stroke [ ] tremors [ ] shaking

Psychiatric
[ ] depression
[ ] anxiety
[ ] eating disorder
[ ] mood changes
[ ] anger issues

Pulmonary
[ ] asthma
[ ] blood in cough
[ ] emphysema
[ ] chronic cough
[ ] shortness of breath

Skin
[ ] rash or itching
[ ] acne
[ ] skin lesions
[ ] other _____

Sleep
[ ] insomnia
[ ] snoring
[ ] nightmares
[ ] do you sleep well? Y N
[ ] do you feel rested after sleep? Y N
[ ] do you often take naps? Y N

Dr Initial____ Patient Signature _____