# 4 PERSONAL HEALTH HISTORY

What treatment have you already received for your condition? ☐Medications ☐Surgery ☐Physical Therapy ☐Chiropractic Care

☐None ☐Other _____

Family Medical Physician (Name, Address, Phone) _____

Place a mark only "Yes" to indicate if you have had any of the following:

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| AIDS/HIV ☐yes ☐No | Ear Infections ☐yes ☐No | Irregular Bowel Movements ☐yes ☐No | Vaccinations ☐yes ☐No |
| Alcoholism ☐yes ☐No | Emphysema ☐yes ☐No | Kidney Problems ☐yes ☐No | Sciatica ☐yes ☐No |
| Allergy Shots ☐yes ☐No | Epilepsy ☐yes ☐No | Liver Problems ☐yes ☐No | Scarlet Fever ☐yes ☐No |
| Anemia ☐yes ☐No | Fractures ☐yes ☐No | Measles ☐yes ☐No | Stomach Ulcers ☐yes ☐No |
| Appendicitis ☐yes ☐No | Glaucoma ☐yes ☐No | Mononucleosis ☐yes ☐No | Stroke ☐yes ☐No |
| Arthritis ☐yes ☐No | Goiter ☐yes ☐No | Multiple Sclerosis ☐yes ☐No | Thyroid Problems ☐yes ☐No |
| Asthma ☐yes ☐No | Gout ☐yes ☐No | Mumps ☐yes ☐No | Recurring Colds ☐yes ☐No |
| Breast Lump ☐yes ☐No | Headaches ☐yes ☐No | Osteoporosis ☐yes ☐No | Recurring Flues ☐yes ☐No |
| Bronchitis ☐yes ☐No | Heart Disease ☐yes ☐No | Pacemaker ☐yes ☐No | Recurring Strep/ Sore Throats ☐yes ☐No |
| Cancer ☐yes ☐No | Hepatitis ☐yes ☐No | Parkinson's Disease ☐yes ☐No | Rheumatoid Arthritis ☐yes ☐No |
| Cataracts ☐yes ☐No | Hernia ☐yes ☐No | Pinched Nerve ☐yes ☐No | Rheumatic Fever ☐yes ☐No |
| Chemical Dependency ☐yes ☐No | Herniated Disk ☐yes ☐No | Pneumonia ☐yes ☐No | Tonslillitis ☐yes ☐No |
| Chicken Pox ☐yes ☐No | High Cholesterol ☐yes ☐No | Polio ☐yes ☐No | Tuberculosis ☐yes ☐No |
| Depression ☐yes ☐No | High Blood Pressure ☐yes ☐No | Prostate Problem ☐yes ☐No | Tumors, Growths ☐yes ☐No |
| Diabetes ☐yes ☐No | Impotence ☐yes ☐No | Prosthesis ☐yes ☐No | Typhoid Fever ☐yes ☐No |
| Digestive Problems ☐yes ☐No | Infertility ☐yes ☐No | Psychiatric Care ☐yes ☐No | Whopping Cough ☐yes ☐No |

# 5 CHILDREN'S HEALTH HISTORY

Number of children? _____ Please check all that apply to any child.

| | | | |
|---|---|---|---|
| Birth | ADD ☐yes ☐No | Digestive Problems ☐yes ☐No | Recurring Colds ☐yes ☐No |
| Breech ☐yes ☐No | Allergies ☐yes ☐No | Ear Infections ☐yes ☐No | Recurring Flues ☐yes ☐No |
| C-section ☐yes ☐No | Appendictis ☐yes ☐No | Growing Pains ☐yes ☐No | Recurring Strep/ Sore Throats ☐yes ☐No |
| Forceps ☐yes ☐No | Asthma ☐yes ☐No | Headaches ☐yes ☐No | Seizures ☐yes ☐No |
| Natural ☐yes ☐No | Bed Wetting ☐yes ☐No | Juvenile Arthritis ☐yes ☐No | Stomach Ulcers ☐yes ☐No |
| Suction Cup ☐yes ☐No | Bowel Problems ☐yes ☐No | Measles ☐yes ☐No | Temper Tantrums ☐yes ☐No |
| Other_____ | Car Accident ☐yes ☐No | Mumps ☐yes ☐No | Tonsillitis ☐yes ☐No |
| | Chicken Pox ☐yes ☐No | Pneumonia ☐yes ☐No | Vaccinations ☐yes ☐No |
| | Colic ☐yes ☐No | | |

**WORK ACTIVITY**

☐Sitting ☐Standing ☐Light Labor ☐Heavy labor

**EXERCISE**

☐None ☐Moderate ☐Daily ☐Heavy

**HABITS**

☐Smoking Packs/Day _____

☐Alcohol Drinks/Week _____

☐Coffee/Caffeine Drinks Cups/Day _____

Injuries/Surgeries you have — Description — Date

Falls, Broken bones, head injuries _____ _____

Other _____ _____

Surgeries (Please include cosmetic/implants) _____ _____

Medications, Vitamins, Herbs currently taking _____

_____

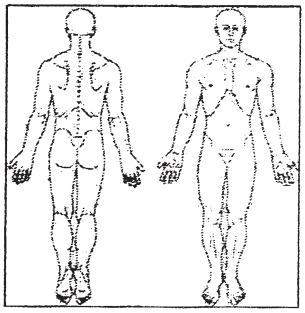
# 6 PATIENT CONDITION

Today's Health complaint: _____

When did this symptom(s) appear? _____

Is this condition getting progressively worse? ☐Yes ☐No ☐Same

Mark an X on the picture where you continue to have pain, numbness, or tingling



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain ☐Sharp ☐Dull ☐Throbbing ☐Numbness ☐Aching ☐Shooting ☐Burning ☐Tingling ☐Cramps ☐Stiffness ☐Swelling ☐Other

Have you seen a chiropractor before? _____ When? _____ Name _____

How often is this pain present? ☐Occasional 0-25% ☐Intermediate 26-50% ☐Frequent 51-75% ☐Constant 76-100%

Does it interfere with your ☐Work ☐Sleep ☐Daily Routine ☐Recreation

Activities or movements that are painful to perform ☐Sitting ☐Standing ☐Walking ☐Bending ☐Lying Down