

GENERAL HEALTH HISTORY

Name _____ Date _____

Check only those conditions that apply to you and indicate if you have had in the past or presently have.

YES	GENERAL QUESTIONS	PAST	PRESENT
<input type="checkbox"/>	I bruise easily	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	I heal slowly	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	My body temperature is normally low (feel cold)*	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Smoke cigarettes or use tobacco products	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Diabetes, hypoglycemia, thyroid disorder, kidney or liver disease, or tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Heart attack or have a heart pacemaker or neck or chest shunt?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Currently or recently had any disease such as AIDS, Tuberculosis, etc	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Do you have difficulties or intolerance to heat packs or ice packs on your skin?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Do you have problems with dizziness, blacking out, balance, fainting, or tripping	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Epilepsy-Seizure-Convulsion history or other neurological disease	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	History of multiple sclerosis, lupus, psoriasis, temporary paralysis, or meningitis	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Cancer history or cancer treatment of any type	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Stroke history (Indicate any suspected strokes or transient ischemic attacks)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Told that you have scoliosis, spondylolisthesis, spina bifida, or fused vertebrae	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Told that you have a bulging/herniated disc or disc degeneration	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Have you ever been hospitalized? Why:	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Blood clots, bleeding or vascular disorder, or told you have an abdominal aneurysm	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Hypertension or high blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Told you have osteoporosis, osteopenia, or ankylosing spondylitis	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Told you have osteoarthritis, rheumatoid arthritis, or gout of your spine or joints	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Do you have any type of breast or pectoralis implants (applies to females & males)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Women Only: Check this box if there is any chance that you are currently pregnant		

FAMILY HISTORY

I have no family history of these conditions) If you have family history of these conditions, please check below:

	Heart Disease	Arthritis	Cancer	Diabetes	Other: _____
Father's Side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mothers's Side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PRIOR INJURY OR MUSCULOSKELETAL PAIN HISTORY

I have no history of previous painful injury or pain) If you have had prior injuries or pain, please check below:

<input type="checkbox"/> Work Injury	<input type="checkbox"/> Fall	<input type="checkbox"/> Sports Injury	<input type="checkbox"/> Lifting Injury	<input type="checkbox"/> Car accident
<input type="checkbox"/> Motorcycle Injury	<input type="checkbox"/> Head Injury	<input type="checkbox"/> Pedestrian Injury	<input type="checkbox"/> Military Injury	<input type="checkbox"/> Other Injury
<input type="checkbox"/> Headaches/Migraines	<input type="checkbox"/> Neck Pain/Arm Pain	<input type="checkbox"/> Middle Back Pain	<input type="checkbox"/> Low Back/Leg Pain	<input type="checkbox"/> Other Pain

FRACTURES/BROKEN BONES

I have never had any broken bones). If you have broken any bones, indicate where and when below:

Region	Year	Region	Year
<input type="checkbox"/> Spinal Vertebra		<input type="checkbox"/> Skull	
<input type="checkbox"/> Collar bone (clavicle)		<input type="checkbox"/> Rib bone	
<input type="checkbox"/> Arm or hand bone		<input type="checkbox"/> Leg or foot bone	
<input type="checkbox"/> Pelvis or hip bones		<input type="checkbox"/> Other	

PREVIOUS SURGERIES

I have never had any surgical procedure). If you have had any previous surgery, indicate type and when:

Surgery	Year	Surgery	Year
<input type="checkbox"/> Spine Surgery (neck, back, or pelvis)		<input type="checkbox"/> Appendix	
<input type="checkbox"/> Disc surgery in neck or back		<input type="checkbox"/> Gallbladder/Stomach/Kidney	
<input type="checkbox"/> Heart		<input type="checkbox"/> Cancer (any type)	
<input type="checkbox"/> Tonsillectomy		<input type="checkbox"/> Rib/Collar bone	
<input type="checkbox"/> Head/Brain		<input type="checkbox"/> Hernia	
<input type="checkbox"/> Shoulder/Arm/Hip/Leg		<input type="checkbox"/> Other	

GENERAL HEALTH HISTORY

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LIST ALL SYMPTOM REGIONS AND HOW LONG YOU HAVE HAD THEM

CHECK ALL SYMPTOM AREAS	HOW LONG	CHECK ALL SYMPTOM AREAS	HOW LONG
<input type="checkbox"/> Headaches/Migraines		<input type="checkbox"/> Upper Back Pain, Soreness, or Stiffness	
<input type="checkbox"/> Neck Pain, Soreness, or Stiffness		<input type="checkbox"/> Hip Pain	
<input type="checkbox"/> Low Back Pain, Soreness, Stiffness		<input type="checkbox"/> Leg or Foot Pain, Numbness, or Tingling	
<input type="checkbox"/> Arm/Hand Pain, Numbness, or Tingling		<input type="checkbox"/> Other:	

Did your symptoms come on Suddenly Gradually

SYMPTOM/PAIN DESCRIPTION

Please circle any word or all words below that best describes how your symptoms currently feel to you.

Pain	Pinching	Spreading	Vicious	Unbearable
Ache	Pricking	Shooting	Sickening	Soreness
Cutting	Tingling	Stabbing	Miserable	Pins and Needles
Tearing	Gnawing	Dull	Troublesome	Radiating
Crushing	Nagging	Bony	Pressing	Weakness
Pulling	Boring	Terrifying	Deep pain	Falls asleep
Irritating	Burning-Hot	Dreadful	Superficial pain	Suffocating
Annoying	Drill like	Fearful	Stinging	Punishing
Stiff or tight	Heavy	Unhappy	Throbbing	Crawling
Exhausting	Numbness	Torturing	Sharp	Tender

Have you ever been to a Chiropractor before for any condition?

No Yes If yes, Chiropractor's Name : _____ Year: _____

Condition/Problem: _____

Do you have any problems laying face down on an examination table?

No Yes If yes, why: _____

ARE YOU TAKING ANY MEDICATIONS?

I am not taking any medications currently. Check any of the following that you are taking currently.

<input type="checkbox"/> Pain/Anti-inflammatory meds	<input type="checkbox"/> Blood pressure/Stroke prevention medications	<input type="checkbox"/> Cortisone injections
	<input type="checkbox"/> Osteoporosis (bone strengthening) medications	<input type="checkbox"/> Other:

WHEN IS PAIN WORSE & WHAT ACTIVITIES INCREASE YOUR PAIN LEVELS?

<input type="checkbox"/> Morning is when pain is worse	<input type="checkbox"/> Bending your back increases pain	<input type="checkbox"/> Walking increases pain
<input type="checkbox"/> Afternoon/evening pain worse	<input type="checkbox"/> Lying down flat increases pain	<input type="checkbox"/> Standing increases pain
<input type="checkbox"/> During sleep hours pain worse	<input type="checkbox"/> Sitting increases pain	<input type="checkbox"/> Exercise/Stretching increases pain
<input type="checkbox"/> Standing up from sitting	<input type="checkbox"/> Poor posture increases pain	<input type="checkbox"/> Other:

HAS YOUR PAIN BEEN ASSOCIATED WITH ANY OF THE FOLLOWING?

<input type="checkbox"/> Excessive fatigue-malaise	<input type="checkbox"/> Bowel or bladder disorders	<input type="checkbox"/> Night pain or night time sweats
<input type="checkbox"/> Weight loss	<input type="checkbox"/> Ovarian pain	<input type="checkbox"/> Abdominal pain
<input type="checkbox"/> Low grade fever	<input type="checkbox"/> Kidney pain/painful urination	<input type="checkbox"/> Balance problems

DO YOU EXERCISE?

<input type="checkbox"/> I do no regular exercise	<input type="checkbox"/> I exercise 1-2 times a week	<input type="checkbox"/> I exercise 3-5 times a week
<input type="checkbox"/> I stretch regularly	<input type="checkbox"/> I do weight lifting at gym/home	<input type="checkbox"/> I do cardiovascular work outs
<input type="checkbox"/> I am willing to do exercise	<input type="checkbox"/> I am not willing to do exercises	<input type="checkbox"/> I do regular sports activities