Present State of Health

List Complaints: List in order of concern.	Date of Onset	How intense is it on a scale of 0 – 10 (0 = No pain, 10 = worst pain ever)	How often does it bother you? 100% - 75% - 50% - 25% of the time?
1. _____	_____	0_1_2_3_4_5_6_7_8_9_10_	_____
2. _____	_____	0_1_2_3_4_5_6_7_8_9_10_	_____
3. _____	_____	0_1_2_3_4_5_6_7_8_9_10_	_____
4. _____	_____	0_1_2_3_4_5_6_7_8_9_10_	_____
5. _____	_____	0_1_2_3_4_5_6_7_8_9_10_	_____

Have you been given a diagnosis for any of these conditions? If so, what?_____
What caused this condition?_____
Has the problem been getting worse, better or staying the same?_____
Last time you had spinal or other x-rays/MRI/CT: _____
If you had previous care for the above complaints, what was done (chiropractic, medication, therapy, surgery, etc.)?_____
_____

Have you received any of the following care prior to this visit?

Chiropractic: Yes / No Name of Doctor:_____ When:_____ Location:_____
Massage: Yes / No Name of LMP:_____ When:_____ Location:_____
Acupuncture: Yes / No Name of LAc:_____ When:_____ Location:_____

List of motor vehicle accidents and major injuries (falls, sports injuries, major traumas, etc.)

Injury: Date:

_____ _____
_____ _____
_____ _____
_____ _____

List of surgeries

Surgery: Date:

_____ _____
_____ _____

Your Personal Birth History (prolonged labor, forceps, premature, etc.): _____
Occupational Stress (chemical, physical, psychological): _____
Allergies (drugs, chemicals, foods, etc.): _____

Habits

Cigarettes _____ per _____ Tea _____ per _____ Alcohol _____ per _____
Soft Drinks _____ per _____ Drugs _____ per _____ Coffee _____per _____

Lifestyle

Current height: _____ Current weight: _____
Type of work: _____ Hours/Day: _____
Physical Activities/Exercise:_____ Hours/Week: _____
Sleep quality: □ POOR □ FAIR □ GOOD Average hours of sleep per night: _____
How are your daily activities affected by your pains/health concerns? _____

Behavioral

□ Vacant □ Easily susceptible to stress □ Panic attacks □ Anxiety □ Fear □ Irritability
□ Moody □ Aggressive/Bad temper □ Substance abuse □ Depression □ Tension □ Isolation
□ Short temper □ Lose control of emotions □ Other_____
Have you ever been treated for emotional problems? □ yes □ no Type of treatment: _____

General Health History

Check all that apply, and for each note if it is current or past.

Musculoskeletal
- □ Headaches
- □ TMJ pain
- □ Neck ache/pain
- □ Shoulder pain
- □ Upper back ache/pain
- □ Mid back ache/pain
- □ Lower back ache/pain
- □ Elbow/Forearm pain
- □ Hand/Wrist pain
- □ Knee ache/pain
- □ Foot/Ankle pain
- □ Joint/Bone problems
- □ Muscle pain/weakness
- □ Hernia
- □ Other_____

Neurological
- □ Seizures
- □ Nerve damage
- □ Paralysis
- □ Difficulty in concentrating
- □ Sleep disorder
- □ Stroke
- □ Concussion
- □ Dizziness
- □ Vertigo
- □ Loss of balance
- □ Lack of coordination
- □ Poor memory
- □ Numbness
- □ Other _____

Head/Eyes/Ears/Nose/Throat
- □ Facial Pain
- □ Sore eyes
- □ Blurry vision
- □ Blindness
- □ Color blindness
- □ Excessive tearing
- □ Hearing difficulty
- □ Snoring
- □ Nasal discharge
- □ Grinding teeth
- □ Hoarseness
- □ Recurrent sore throat
- □ Toothaches
- □ Other _____

Cardiovascular
- □ Pacemaker
- □ High blood pressure
- □ Low blood pressure
- □ Chest discomfort/pain
- □ Heart palpitations
- □ Cold hands or feet
- □ Swelling of hands or feet
- □ Blood clots
- □ Varicose veins
- □ Fainting
- □ Ankle swelling
- □ Other_____

Respiratory
- □ Difficulty breathing
- □ Shortness of breath
- □ Shallow breathing
- □ Wheezing
- □ Production of phlegm
- □ Recurrent cough
- □ Bronchitis
- □ Other

_____

Genito-Urinary
- □ Painful urination
- □ Frequent urination
- □ Discolored urine
- □ Blood in urine
- □ Incontinence
- □ Vaginal pain/Infection
- □ Prostate/Sexual dysfunction
- □ Change in sexual drive
- □ Impotency
- □ Other _____

Gastro-Intestinal
- □ Poor/Excessive appetite
- □ Excessive thirst
- □ Frequent nausea
- □ Vomiting
- □ Diarrhea
- □ Constipation
- □ Abdominal cramps
- □ Hemorrhoids
- □ Weight problems
- □ Liver problems
- □ Other _____

General
- □ Recurrent infections
- □ Fatigue
- □ Poor sleep
- □ Sudden energy drops
- □ Sweat easily
- □ Night sweats
- □ Bleed or bruise easily
- □ Skin issues
- □ Tremors
- □ Edema
- □ Other _____

List of Medications & Supplements

Medication/Supplement	Dosage & How often?
_____	_____
_____	_____
_____	_____
_____	_____

Gynecological (For Women)

When was your last period? _____

Are you pregnant? □ yes □ no □ unsure

If yes, due date: _____

□ PMS □ Painful periods

□ Light periods □ Heavy periods

□ Irregular menstruation

□ Menstrual cramps

□ Other _____

Diseases

□ Mental Illness	□ AIDS	□ Chronic Fatigue	□ Rheumatic Fever	□ Heart Disease	□ Ulcers
□ Diabetes	□ Herpes	□ Gall Stones	□ Thyroid Problems	□ Asthma	□ Kidney Stones
□ Hepatitis	□ Stroke	□ Osteoporosis	□ Parasites	□ Allergies	□ Venereal Disease
□ Arthritis	□ HIV+	□ Mononucleosis	□ Cancer	□ Seizures	□ High Blood Pressure

□ Other _____

Family Health History

F=Father M=Mother S=Sibling G=Grandparent

Place the appropriate letter(s) in the blank if someone in your family has/had any of the following:

□ Mental Illness	□ AIDS	□ Chronic Fatigue	□ Rheumatic Fever	□ Heart Disease	□ Ulcers
□ Diabetes	□ Herpes	□ Gall Stones	□ Thyroid Problems	□ Asthma	□ Kidney Stones
□ Hepatitis	□ Stroke	□ Osteoporosis	□ Parasites	□ Allergies	□ Venereal Disease
□ Arthritis	□ HIV+	□ Mononucleosis	□ Cancer	□ Seizures	□ High Blood Pressure

□ Other _____

Patient/Guardian Signature:_____ **Date:** _____