About Your Health……

Patient Name: _____

The human body is designed to be healthy. Throughout life, events occur which damage your health expression. This case history will uncover the layers of damage, especially to your nervous system, that have resulted in your lowered state of health.
At your report of findings, your Chiropractor will outline a course of care to begin to correct the layers of damage and recover your innate health potential.

PRESENT HEALTH: Are you presently affected by any of the following? **(Within past 6 months)**

O-OCCASIONAL F-FREQUENT C-CONSTANT

MUSCLE AND JOINT	O	F	C
Backache	□	□	□
Neck pain/stiffness	□	□	□
Painful tailbone	□	□	□
Foot trouble	□	□	□
Shoulder pain	□	□	□
Hernia	□	□	□
Spinal curvature	□	□	□
Faulty posture	□	□	□
Arthritis	□	□	□
Upper back pain	□	□	□
Hip pain	□	□	□
Knee pain	□	□	□

CARDIOVASCULAR	O	F	C
Rapid heart beat	□	□	□
Slow heart beat	□	□	□
High blood pressure	□	□	□
Low blood pressure	□	□	□
	□	□	□
Swelling of ankles	□	□	□
Previous heart attack	**Yes** □	**No** □	
Poor circulation	**Yes** □	**No** □	
Previous stroke	**Yes** □	**No** □	
Chest pain	**Yes** □	**No** □	

FEMALES ONLY

Painful menstruation	**Yes** □	**No** □
Irregular	**Yes** □	**No** □
Excessive flow	**Yes** □	**No** □
Cramps or backache	**Yes** □	**No** □
Abnormal discharge	**Yes** □	**No** □
Passed menopause	**Yes** □	**No** □
Are you pregnant?	**Yes** □	**No** □
Birth control pill	**Yes** □	**No** □

Number of miscarriages_____

Date of last menstrual period_____

GENERAL SYMPTOMS	O	F	C
Fever/Chills/Sweat	□	□	□
Fainting	□	□	□
Convulsions	□	□	□
Allergy	□	□	□
Skin problems	□	□	□
Colds	□	□	□
Tremors	□	□	□
Loss of balance	□	□	□
Head too heavy	□	□	□

RESPIRATORY	O	F	C
Chronic cough	□	□	□
Spitting up blood/phlegm	□	□	□
Chest pain	□	□	□
Difficult breathing	□	□	□

EYES, EARS, NOSE, THROAT	O	F	C
Deafness	□	□	□
Earache	□	□	□
Sore throat	□	□	□
Asthma	□	□	□
Tonsillitis	□	□	□
Sinus trouble	□	□	□
Ringing in ears	□	□	□
Buzzing in ears	□	□	□

URINARY	O	F	C
Painful urination	□	□	□
Waking up to urinate	□	□	□
Increased urination	□	□	□
Blood in urine	□	□	□

GASTROINTESTINAL	O	F	C
Difficult digestion	□	□	□
Belching or gas	□	□	□
Nausea or vomiting	□	□	□
Pain over stomach	□	□	□
Constipation	□	□	□
Colon trouble	□	□	□
Liver trouble	□	□	□
Gall bladder trouble	□	□	□
Heartburn	□	□	□
Diarrhea	□	□	□
Bloody stools	□	□	□

STRESS SYMPTOMS	O	F	C
Headache/Migraine	□	□	□
Dizziness	□	□	□
Numbness/pins & needles in any arms			
hands/legs/feet	□	□	□
Ringing in ears	□	□	□
Blurring of vision	□	□	□
Loss of sleep	□	□	□
Loss of concentration/memory	□	□	□
Irritable/nervousness	□	□	□
Depression	□	□	□
Decreased energy/fatigue	□	□	□
Tension	□	□	□

PLEASE CIRCLE WHICH APPLIES

Did/Do you smoke? **Yes** □ **No** □
Did/Do you drink alcohol? **Yes** □ **No** □
Did/Do you take drugs? **Yes** □ **No** □
(Prescriptive/Non-prescriptive)
On a scale of 1 to 10, describe your stress level? **Home:** _____ **Work:** _____
Please circle which way you sleep?
Stomach / Side / Back

PAST HEALTH: Have you **ever** suffered from any of the following conditions?

Thyroid trouble **Yes** □ **No** □	Tuberculosis… **Yes** □ **No** □	Emotional problems.. **Yes** □ **No** □	Psoriasis…… **Yes** □ **No** □
Diabetes …… **Yes** □ **No** □	Pneumonia….. **Yes** □ **No** □	Epileptic seizures….. **Yes** □ **No** □	Polio…… **Yes** □ **No** □
High blood pressure…… **Yes** □ **No** □	Back pain…….. **Yes** □ **No** □	Asthma…….. **Yes** □ **No** □	Cancer…… **Yes** □ **No** □
Heart disease…….. **Yes** □ **No** □	Headaches…… **Yes** □ **No** □	Arthritis……. **Yes** □ **No** □	Venereal disease…. **Yes** □ **No** □
Allergies …….. **Yes** □ **No** □	Stomach ulcers. **Yes** □ **No** □	Alcoholism…… **Yes** □ **No** □	HIV…… **Yes** □ **No** □

FAMILY HISTORY

Heart Disease	**Yes**	**No**	Cancer	**Yes**	**No**	Back Problems	**Yes** **No**
Stroke	**Yes**	**No**	Arthritis	**Yes**	**No**	**Other:**_____	
Diabetes	**Yes**	**No**	High Blood Pressure	**Yes**	**No**	_____	

DATE	ILLNESS/ OPERATION

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