**Patient Health History**

/ /

**Today’s Date Signature of Patient**

**Patient Title:** *(check one)* ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Dr. ❑ Prof. ❑ Rev.

**First Name** **Nick Name**

**Last Name Middle Name Suffix**

**Address 1**

**Address 2**

**City State Zip Code**

**Primary Phone Secondary Phone**

**Mobile Phone**

**Home email**   **Work Email**

*By providing my email address, I authorize my doctor to contact me via the email address(es) provided.*

**Which email address would you like us to use to communicate with you?** *(check one)*❑ Home ❑ Work

**Contact Method** *(check one)*

❑ Primary Phone ❑ Secondary Phone ❑ Mobile Phone ❑ Home Email ❑ Work Email

/ /

**Date of Birth Age**  **Gender** *(check one)* ❑ Male ❑ Female ❑ Unspecified

**Marital Status** *(check one)* ❑ Single ❑ Married ❑ Other

**Employment Status** *(check one)*

❑ Employed ❑ FT Student ❑ PT Student ❑ Other ❑ Retired ❑ Self Employed

**Race** *(check one)*

❑ White ❑ Black/African American ❑ Hispanic ❑ American Indian/Alaskan Native

❑Other \_ \_\_\_\_\_\_\_\_\_\_ ❑ I choose not to specify

**Multi-Racial** *(check one)* ❑Yes ❑No ❑ Unknown

**Ethnicity** *(check one)* ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ I choose not to specify

**Preferred Language** *(check one)*

❑ English ❑ Spanish ❑ American Sign Language ❑ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

❑ I choose not to specify

**Referred by:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you currently smoke tobacco of any kind?** ❑ Yes ❑ Former smoker ❑ Never been a smoker

***If yes, how often do you smoke:*** ❑ Current every day smoker ❑ Current sometimes smoker

***If yes, what is your level of interest in quitting smoking?***

 0       1       2       3       4       5       6       7       8       9       10

*No interest       Very Interested*

**Do you currently drink alcohol of any kind?** ❑ Yes ❑ No

***If yes, how much do you drink per week:*** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***What type of drink do you primarly drink:*** ❑ Wine ❑ Beer ❑ Liquor

**Do you use any illegal drugs?** ❑ Yes ❑ No

**Current medications, including frequency and dosage if known. If there are no current medications,**

**check here: ❑**

Start Date

Start Date

**1) 5)**

**2) 6)**

**3) 7)**

**4) 8)**

**List any known allergies you have had to any medications.**

**If no allergies are known, check here: ❑**

**1) 3)**

**2) 4)**

**FAMILY HISTORY: please list if your mother, father, sisters or brothers have had...**

**DIABETES\_\_\_\_\_\_\_\_\_\_\_\_\_CANCER\_\_\_\_\_\_\_\_\_\_\_\_\_\_TUBERCULOSIS\_\_\_\_\_\_\_\_\_\_\_\_\_OTHER\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Has any doctor diagnosed you with Hypertension presently?** ❑ Yes ❑ No If yes, describe:

**Has any doctor diagnosed you with Diabetes presently?** ❑ Yes ❑ No If yes, what kind? ❑ Type I ❑ Type II

***If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%?*** ❑ Yes ❑ No ❑ Not Sure

***If yes, other comments regarding Diabetes:***

**Have you had an X-ray or CT scan or MRI of your low back spine in the past 28 days?** ❑ Yes ❑ No

**To be performed by clinic staff:**

**Height:** inches **Weight:** pounds **BP:** /

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| humans | | | | | |  | | | | | | | | | | | | | | | | | | | |
| **PLEASE DESCRIBE YOUR PRESENT PAIN FULLY AND ILLUSTRATE AND OUTLINE ON DRAWING.** | | | | | | | | | | | | | | | | | | | |
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| **WHEN DID THIS PAIN OCCUR?** | | | |  | | | | | | | **WHAT WERE YOU DOING?** | | | | | | | | |  | | | | | |
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|  | | | | | | **HAVE YOU EVER HAD THIS PAIN BEFORE ?** | | | | | | | | | | | |  | | | | | | | |
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| **DOES THIS PAIN HURT WORSE WHEN YOU SIT?** | | | | | | |  | | | | **STAND** | | |  | | **MOVE ABOUT** | | | | | | |  | | |
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| **DOES THE PAIN INVOLVE A HIP** | | | | |  | **LEG** | | |  | | **ANKLE** | | |  | | **FOOT** | | |  | | | **WHICH ONE** | | |  |
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| **DOES YOUR LEG BECOME NUMB?** | | | | |  | **DOES YOUR FOOT FEEL NUMB** | | | | | | | | |  | | **DOES YOUR BACK HURT WORSE** | | | | | | | | |
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| **WHEN IN BED?** |  | **DO YOU HAVE NIGHT SWEATS?** | | | | | | | |  | | **DOES IT PAIN YOU WHEN YOU BEND FORWARD?** | | | | | | | | | | | |  | |
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| **IS YOUR PAIN CONSTANT?** | | |  | | **GIVE YOUR CHIROPRACTIC HISTORY** | | | | | | | | | |  | | | | | | | | | | |
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| **RESULTS FROM PREVIOUS CHIROPRACTIC CARE** | | | | | | | |  | | | | | | | | | | | | | | | | | |
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| **WHAT APPLICATIONS HELP** | | | |  | | | | | | | | | **WORSEN** | |  | | | | | | | | | | |
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| **HAVE YOU BEEN X-RAYED DURING THE PAST SIX MONTHS** | | | | | | | | | | |  | | | | **WHAT WAS X-RAYED** | | | | | |  | | | | |
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| **LIST WHAT YOU HAD FOR BREAKFAST:** | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **LUNCH:** | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **SUPPER:** | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **HOW MUCH COFFEE DO YOU DRINK EACH DAY?** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | **BLACK** | | | | |  | | | **CREAM** | | | | | | |  | | | | | **SUGAR** | | | | | **ARTIFICIAL SWEETENER** | |  | | |
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| **LIST YOUR ACCIDENT’S AND GIVE DATE’S** | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **LIST YOUR MAJOR DISEASES AND GIVE DATE’S** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **SURGERY:** | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **YOUR PRESENT COMPLAINT:** | | | | | | | | | | | | | | | | **Does your present complaint involve any of the following:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **HEART PAINS** | | | | |  | | | | **LEFT CHEST PAINS** | | | | | | | | | | | | | | | | | | | |  | | | | | | **RIGHT CHEST PAINS** | | | | | | | | | | | | | | |  | | | | | **LEFT ARM PAINS** | | | | | | | | | | |  | |
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| **RIGHT ARM PAINS** | | | | | | | |  | | | **IS YOUR PAIN WORSE ON EXERTION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | **SITTING** | | | | | | | | | | | |  | | | **STANDING** | | | |  | |
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| **DOES YOU PAIN INVOLVE . . .** | | | | | | | | | | | | | **STOMACH** | | | | | | | | | | |  | | | | | | | | | **RIGHT LOWER RIBS** | | | | | | | | | | | | | | | |  | | | | | | | **LEFT LOWER RIBS** | | | | | | | |  | | | |
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| **DOES YOU PAIN APPEAR BEFORE . . . . .** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **EATING** |  | | | **AFTER EATING** | | | | | | | | | | | | |  | | | | | | **1 HOUR AFTER** | | | | | | | | | | | | | | | | |  | | | | **2 HOURS AFTER** | | | | | | | | | | | | |  | | | | **3 HOURS AFTER** | | | | |  | |
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| **DO YOU HAVE HEADACHES** | | | | | | | | | | | | | |  | | | | | **WHAT PART OF YOUR HEAD IS INVOLVED?** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | |
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| **DOES YOUR HEADACHE APPEAR WHEN YOU AWAKEN IN THE MORNING?** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | **BEFORE NOON** | | | | | | | | | | | | | | |  | |
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| **BEFORE SUPPER** | | | | | |  | | | | **BOWEL FUNCTION; Are you constipated?** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | **Is your stool Hard?** | | | | | | | | |  | |
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| **Marble like** | | |  | | | | | **Watery** | | | | | | | | |  | | | | | | **Do you see long strings of mucus in your stools** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
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| **DO YOU GET UP NIGHTS TO URINATE** | | | | | | | | | | | | | | | | | | | | |  | | | | | | **HOW OFTEN** | | | | | | | | | | | | |  | | | | **BURNING** | | | | | | | | | |  | | | | | | **DISCOLORATION** | | | | | |  | |
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| **DOES YOUR URINE STAIN YOUR UNDERCLOTHING** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | **DO YOU FEEL AS THOUGH YOUR BLADDER DID NOT EMPTY** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
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| **DO YOU SUFFER FROM GAS** | | | | | | | | | | | |  | | | | | **IS YOUR MOUTH OR TOUNGE SORE** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | **DO YOU HAVE CANKER SORES** | | | | | | | | | | | | | |  | |
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| **ARE YOU SHORT OF BREATH** | | | | | | | | | | | | | | |  | | | | **DO YOU COUGH** | | | | | | | | | | | | | | | | | | | | | | |  | | | **DO YOU WORRY UNNECESSARILY** | | | | | | | | | | | | | | | | | | | | |  | |
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| **DO YOU DREAM** | | | | | | |  | | | | **HAVE YOUR HANDS EVER TREMBLED WHILE YOUR WORKING** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
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| **DO YOU LEGS FEEL WEAK AT TIMES** | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **HAVE YOU ANY DIZZINESS** | | | | | | | | | | | | | | | |  | |
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| **DO YOUR HANDS OR FEET BECOME COLD** | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | **NUMB** | | | | | | |  | | | **DO YOUR EYES TROUBLE YOU** | | | | | | | | | | | | | | | | | | | | | | | |  | |
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| **DOES THE COMPANY OF PEOPLE BOTHER YOU** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | **DOES YOUR THROAT BECOME PAINFUL** | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
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| **DOES YOU VOICE BECOME HOARSE** | | | | | | | | | | | | | | | | | | | |  | | | | | | | | **DO YOU HAVE HEAD OR EAR NOISES** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
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| **DO YOU HAVE SPOTS BEFORE YOUR EYES** | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |