

# GENERAL HEALTH HISTORY

Patient Name \_\_\_\_\_ *Mark the conditions that apply to you.*

**Past Present**

- Headaches
- Migraines
- Shortness of Breath
- Allergies / Asthma
- Medication Side Effects
- Diabetes
- Hands or Feet cold
- Muscle aches
- Trouble Walking
- Leg / Foot Numbness
- Fainting
- Gall Bladder Trouble
- Ringing in Ears
- Ear Problems
- Sleeping Problems
- Vision Problems
- Thyroid Problems
- Liver Disease
- Kidney Problems
- Light Bothers Eyes
- Other \_\_\_\_\_

**Past Present**

- Urinary Problems
- Easy Bruising
- Tobacco Use
- Dental Problems
- Fibromyalgia
- Blood Thinner use
- HIV Positive
- Cancer
- Depression
- Alcohol Use
- \_\_\_High or \_\_\_Low Blood Pressure
- Stroke History
- High Cholesterol
- TMJ
- Digestive Problems
- Pain all Over
- Tension / Irritability
- Chest Pains
- Heart Pacemaker
- Heart Problems

1. List any medications are you taking: \_\_\_\_\_

2. Please list all doctors you are currently seeing: \_\_\_\_\_

3. Has any Doctor or other professional advised you to "Go to a Chiropractor ":  No  Yes, Name \_\_\_\_\_

## PAST HISTORY

4. List any past auto collisions: \_\_\_\_\_ Was any care received? \_\_\_\_\_

5. List any past work injuries: \_\_\_\_\_ Was any care received? \_\_\_\_\_

6. List any past sport, recreational, or home injuries \_\_\_\_\_

7. Please describe any past conditions and treatment received: \_\_\_\_\_

8. Please list any past hospitalizations and surgeries: \_\_\_\_\_

## FAMILY HISTORY

Father's side:  Heart Disease  Cancer  Diabetes  Heavy Medication use  Arthritis  Other \_\_\_\_\_

Mother's side:  Heart Disease  Cancer  Diabetes  Heavy Medication use  Arthritis  Other \_\_\_\_\_

Is there any other family history you want us to know? \_\_\_\_\_