**HEALTH HISTORY FORM**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_Sex: M F

Family physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date physician was last seen: \_\_\_\_\_\_\_\_

Have you **ever** had surgery? Yes □ No □

Have you **ever** been diagnosed with a long-term or ongoing health problem? Yes □ No □

Have you **ever** been diagnosed with cancer? Yes □ No □

Have you been sick at all in the last 60 days? Yes □ No □

Have you **ever** had a convulsion, seizure or stroke of any kind? Yes □ No □

Have you **ever** passed out, blacked out or fainted? Yes □ No □

Have you been dizzy or lightheaded in the last 60 days? Yes □ No □

Do you have any unusual vision or hearing problems recently? Yes □ No □

Have you had ringing in your ears in the last 60 days? Yes □ No □

Have you had a headache in the last 60 days? Yes □ No □

Have you **ever** had a heart attack or been diagnosed with a heart condition? Yes □ No □

Have you **ever** been diagnosed with high or low blood pressure? Yes □ No □

Do you have frequent colds, sinus infection, ear infections or sore throats? Yes □ No □

Do you have asthma or any allergies? Yes **□** No □

**Males**, have you **ever** been diagnosed with a prostate problem? Yes □ No □

Do you have trouble controlling urination? Yes □ No □

Have you had frequent or painful urination in the last 60 days? Yes □ No □

Have you had a kidney or bladder infection in the last 60 days? Yes □ No □

Do you have a problem with re-occurring kidney/bladder infections? Yes □ No □

Have you been constipated or had diarrhea in the last 60 days? Yes □ No □

Do you have any sores or skin lesions that aren’t healing? Yes □ No □

Have you had weakness, twitching or tremors in your arms/hands or legs/feet in the last 60 days? Yes □ No □

Have you **ever** broken a bone or dislocated a joint? Yes □ No □

Have you **ever** had a motor vehicle accident or fender bender? Yes □ No □

Have you **ever** had a fall or injury that required professional attention? Yes □ No □

Have you **ever** been given a permanent disability rating? Yes □ No □

Have you **ever** had a spinal x-ray, MRI or CAT scan? Yes □ No □

Have you **ever** had chiropractic care before? Yes □ No □

List of allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

– OVER –

 **HEALTH HISTORY FORM**

List **ALL** medications you are presently taking. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ For what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(include birth control pills and over-the-counter meds) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ For what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ For what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HABITS**

Do you smoke or chew tobacco? Yes □ No □

How much coffee/tea do you typically consume a day? None □ 1-2 cups □ 3-7 cups □ 8 or more cups □

How much soda/pop do you typically consume a day? None □ 1-2 cups □ 3-7 cups □ 8 or more cups □

How much alcohol do you typically consume in a week? None □ 1-2 drinks □ 3-7 drinks □ 8 or more drinks □

Typical physical activity at work? mostly sitting □ light manual labor □ manual labor □ heavy manual labor □

General physical activity when not working? mostly sitting/relaxing □ usually active □ usually very active □

Outside of work, do you exercise on a regular basis? Yes □ No □

**FAMILY HEALTH HISTORY**

How is your father’s health? Good □ Fair □ Poor □ Deceased □

How is your mother’s health? Good □ Fair □ Poor □ Deceased □

How is your siblings’ health? Good □ Fair □ Poor □ Deceased □

List any health problems that run in your family:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has anyone in your immediate family ever had a stroke? Yes □ No □

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| **FEMALES ONLY** |

Date of last OB/GYN exam: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Were the results of your last OB/GYN exam/pap smear normal? Yes □ No □ Unsure □

Age of each of your children: \_\_\_\_, \_\_\_\_, \_\_\_\_, \_\_\_\_, \_\_\_\_, \_\_\_\_

Circle each symptom/problem you have had in the past year:

painful periods excessive flow during period PMS yeast infection

hot flashes crams or backache during cycle vaginal discharge miscarriage

Are you pregnant? Yes □ No □ Unsure □

Is there a chance that you might be pregnant? Yes □ No □

When did your last menstrual period begin? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have irregular cycles? Yes □ No □ Unsure □

Are you taking oral contraceptives? Yes □ No □ Unsure □

Do you have an IUD? Yes □ No □ Unsure □

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| --- |
| **PREGNANCY WARNING AND CONSENT TO X-RAY** |

I understand that if I am pregnant and have x-rays taken which expose my lower torso to radiation, it is possible to injure the fetus.

I have been advised that if there is a chance that I might be pregnant the 10 days following onset of a menstrual periods are generally considered to be the safest time for an x-ray examination.

With full understanding of the above, and believing I am not currently at risk, I give the doctors of Seymour Chiropractic permission to perform an x-ray examination on me if they feel it is necessary.

Patient’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_