File #:

Doctor's Name _____ Referred By _____ Date _____

PATIENT HEALTH HISTORY **Re-evaluation:** [ ]Yes

1. Name: _____ Gender: [ ]M, [ ]F Age: _____ Height: _____ Weight: _____
   Address: _____
   Phone: _____ E-mail: _____ Birthday: _____
   Primary Physician: _____ Phone: _____ Fax: _____
   Primary Physician's Email: _____

2. Have you ever used: [ ]Chiropractic Treatment [ ]Chinese Herbal Medicine [ ]Acupuncture [ ]Homeopathy
   If yes, for which conditions? _____
   If no, would you like to hear about options for your condition (please circle)? Yes No

3. What is the reason for your visit? What is your chief complaint? (Describe your condition at its worst)
   _____
   _____
   Other Complaints: _____
   Diagnosed Medical Conditions: _____

4. Cause of Health Conditions: [ ] Injury [ ] Auto Accident [ ] Personal Injury [ ] Other: _____ Has the accident been reported? Yes No Reported to: [ ]Employer [ ]Auto Carrier [ ]Other: _____ Are you now or have you ever been disabled? Yes No Date: _____ Cause:_____
   Have you ever retained an attorney? Yes No Name: _____ Phone: _____

5. Pain Symptoms: a._____ Began (Mo/Yr) _____ Previous Episodes (Mo/Yr)_____
   (In Order b._____ Began (Mo/Yr) _____ Previous Episodes (Mo/Yr)_____
   of Severity) c._____ Began (Mo/Yr) _____ Previous Episodes (Mo/Yr)_____

6. Please circle areas of pain or discomfort and mark them using the codes listed below:

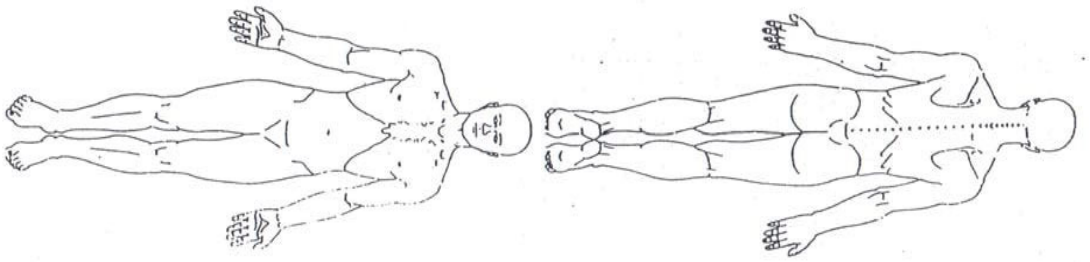
   N=Numbness, T=Tingling, B=Burning, P=Pain, S=Soreness, A=Ache, SB=Stabbing, SF=Stiffness, X=Scars
   List the frequency and severity of your condition on a scale of 1 to 5:

Frequency:	Severity:
1=20% of the time	1=Annoying
2=40% of the time	2=Impairment to Activity
3=60% of the time	3=Need Medication
4=80% of the time	4=Impairment with Medication
5=100% of the time	5=Severe (Need Hospitalization)

	Location	Frequency	Severity	Initial Cause	Getting Worse?
a.	_____	_____	_____	_____	Yes No
b.	_____	_____	_____	_____	Yes No
c.	_____	_____	_____	_____	Yes No

   Does it affect other areas of your body (please circle)? Yes No If yes, explain: _____

7. Do you have, or have you ever had:



Osteoarthritis ___
Bone Spurs ___ Non-union Fracture ___ Ganglion or Baker's Cyst ___
Bulging Disc ___ Tendonitis___ Avascular Necrosis ___ Cartilage injury ___
Herniated Disc ___ Joint Separations ___ Post-herpetic neuralgia ___ (Meniscus Tear, Chondromalacia
DDD ___ Bursitis ___ Intercostal Neuralgia ___ Patellar Syndrome)
Stenosis ___ Sprains ___ Morton's Neuroma ___

8. Does the condition interfere with (please circle): Work Sleep Other: _____
Please describe: _____
Without treatment, how would it affect your quality of life? _____
_____

9. What seems to make the condition better? _____
What seems to make it worse? _____
What treatments have you tried? _____

10. If you are currently under the care of a health care practitioner for any conditions or injuries, please provide their:
Name: _____ Phone: _____ Email: _____
Description of Treatment: _____

11. Please list any current therapies: _____

12. Please describe your lifestyle (please circle):

Appetite: Low Moderate High
Thirst for Water: Yes No _____ Glasses/Day
Coffee: Yes No _____ Cups/Day
Soda: Yes No _____ Cups/Day
Artificial Sweeteners: Yes No
Cravings for Sugar: Yes No
Cravings for Salty Foods: Yes No
Stress Level: High Moderate Low
Alcohol: Yes No _____ Glasses/Day
Smoking: Yes No _____ Cigarettes/Day
Marijuana: Yes No _____ Times/Day
Other Drugs : _____
Occupational Hazards: _____

Exercise (please circle):

None Very Active
Light Elite Athlete
Moderate
Active

Type of Exercise: _____
Frequency of Exercise: _____

13. List vitamins or supplements taken in the last 2 months: _____

14. List prescribed and over-the-counter pharmaceutical medication taken in the last 2 months:
Anti-acids (please check): [ ] TUMS [ ] Zantac [ ] Other: _____
Proton Pump Inhibitors (please check): [ ] Prilosec [ ] Pepcid [ ] Prevacid [ ] Other: _____
Other Medications: _____
_____ 15.
Please describe your health history (please check).

Now Past **Now Past** **Now Past** **Now Past**

___ ___ Drug Withdrawal ___ ___ IBD ___ ___ Rheumatic Fever
___ ___ Emphysema ___ ___ IBS ___ ___ Rheumatoid Arthritis
___ ___ Epilepsy ___ ___ Kidney Stone ___ ___ Sarcoidosis ___
___ ___ Eczema ___ ___ Lyme Disease ___ ___ Fatty Liver ___ ___ Measles ___ Scoliosis
___ ___ Fibromyalgia ___ ___ Mental Disorder ___ ___ Fibroid ___ ___ Migraines ___ ___ Scarlet Fever
___ ___ Gall Bladder Stone ___ ___ Multiple Sclerosis ___ ___ Seizures
___ ___ Goiter ___ ___ Mump ___ ___ Stroke
___ ___ Gout ___ ___ Ovarian Cyst ___ ___ Thyroid Disorders ___
___ ___ Hernia ___ ___ Pacemaker ___ Tuberculosis
___ ___ Heart Disease:_____ ___ ___ Pancreatitis ___ ___ Typhoid Fever
___ ___ Heart Murmur ___ ___ Pleurisy ___ ___ Ulcers, Location: _____
___ ___ Hepatitis ___ ___ Pneumonia ___ ___ UTI ___ ___ Ulcerative Colitis ___
___ ___ Acid Reflux/Heart Burn ___ ___ Diverticulitis ___ ___ Influenza ___ ___ Pulmonary Fibrosis ___ Crohn's Disease
___ ___ AIDS/HIV ___ ___ Bronchiectasis ___ ___ Breast Lump ___ ___ Cancer
___ ___ Alcoholism ___ ___ Chicken Pox
___ ___ Allergies ___ ___ ___ Chronic Bronchitis ___ ___ Cirrhosis ___ ___ COPD
___ Anemia ___ ___ Cystic Fibrosis ___ ___ Diabetes
___ ___ Appendicitis ___ ___ Herpes ___ ___ Prostatitis ___ ___ Interstitial Cystitis ___ ___ High Blood Pressure
___ ___ Arthritis ___ ___ Polio ___ ___ Vitiligo
___ ___ Arteriosclerosis ___ ___ High Cholesterol ___ ___ Psoriatic arthritis ___ ___ Venereal Disease
___ ___ Asthma ___ ___ Hyperlipidemia ___ ___ Psoriasis ___ ___ Whooping Cough
___ ___ Birth Trauma ___ ___ Other, Describe _____

16. Please use the point scales to rate your symptoms over the past 3 months.

1 = **Occasional, Not Severe** **3 = Frequent, Not Severe**
2 = **Occasional, Severe** **4 = Frequent, Severe**

Digestive Tract
___Acid reflux/Heart Burn
____Poor Digestion
____Nausea & Vomiting
_____Bloating
_____Gas
_____Hiccups
_____Bad Breath
_____Gluten Intolerance
_____Food Allergies
_____Chemical Sensitivities
_____Malnutrition
_____Difficulty Swallow
_____Achalasia
_____Diarrhea
_____Constipation

____Laxative Use
____Blood in Stool
____Mucous in Stool
____Black Stool
___Stomach Pains/Cramps
___Abdominal Pain
___Abdominal Spasms
___Lack of Bowel Control
___Itchy Anus
___Rectal Pain
___Hemorrhoids
___Anal Fissures
Bowel Movements:
Frequency_____
Color_____
Texture/Form_____
Odor_____

___Other Kidney Problems

Weight & Eating
___Recent Weight Loss/Gain
___Binge Eating/Drinking
___Craving Certain Foods
___Excessive Weight Eating
___Poor Appetite
___Heavy Appetite
___Strongly Like Cold Drinks
___Strongly Like Hot Drinks
___Water Retention

Musculoskeletal
___Muscle Pains
___Muscle Cramps
___Pains or Aches in Joints

___Learning Disability

Neurological
___Seizures
___Numbness
___Tics
___Foot Neuropathy ___Compulsive

Energy & Activity
___Apathy, Lethargy
___Attention Deficit
___Fatigue
___Lack of Strength
___Body Heaviness
___Hyperactivity
___Restlessness
___Shortness of Breath
___Stuttering or Stammering

General

___Sweat Easily
___Night Sweats
___Gall Bladder Troubles
___Cold Hands or Feet
___Poor Circulation
___Shortness of Breath
___Spitting Blood
___Fever
___Chills
___Muscle Cramps
___Lower Extremity Edema
___Vertigo or Dizziness
___Bleed or Bruise Easily
___Frequent Illness
___Seasonal Allergy
___Addicted to Drugs
___Addicted to Smoking
___Peculiar Taste:
Describe: _____

Respiratory

___Tight Chest
___Difficulty Breathing When Lying Down
___Itching Inside the Chest
___Wheezing
___Persistent Cough
___Coughing Blood
___Cough: Wet / Dry, Thick / Thin
Color of Phlegm_____
___Other Lung Problems

Urinary

___Blood in Urine
___Lack of Bladder Control
___Pain During Urination
___Abuse Survivor
___Night Blindness
___Incomplete Urination
___Other Liver Problems
___Prostate Problem
___Kidney Stone
___Kidney Failure
___Recurrent Bladder Infections

___Stiffness/Limited Range of Motion
___Limited Use
___Pains or Aches in Muscles
___Feeling of Weakness/Tiredness
___Swollen Tender Joints
___Growing Pains in Legs
___Hip Tightness/Coldness/Pain
___Rib Pain
___Neck/Shoulder Pain
___Upper Back Pain
___Back Pain
___Lower Back Pain
___Sciatic Pain

Cardiovascular

___Heart Murmur
___Heart Palpitations
___Irregular or Skipped Heartbeat
___Rapid or Pounding Heartbeat
___Chest Pain
___Shortness of Breath
___Difficulty Breathing
___High Blood Pressure
___Low Blood Pressure
___Blood Clots ___Anemia
___Fainting
___Vein Inflammation
___Tachycardia

Emotions

___Mood Swings
___Anxious, Fear, Nervous
___Angry Irritable, Aggressive
___Easily Stressed
___Argumentative
___Frustrated, Cries Easily
___Depression
___Spots in Eyes Urination
___Seeing a Therapist
___Cataract

Mind

___Poor Memory ___Difficulty Completing Projects
___Difficulty with Mathematics
___Underachiever
___Poor/Short Attention Span
___Confusion
___Difficulty Making Decisions

Head

___Headaches ___Migraines ___Genital Itch or Discharge
___Faintness
___Dizziness

___Impotence
___Decreased Libido
___Premature Ejaculation
___TMJ

___Slurred Speech

Ears

___Itchy Ears
___Ear Aches, Ear Infections
___Drainage from Ears
___Hearing Loss
___Reddening of the Ears
___Ringing in the Ears
___Headaches
___Concussions

Nose

___Stuffy Nose
___Dryness Inside the Nose
___Chronically Red, Inflamed Nose
___Sinus Problem ___Hay Fever
___Sneezing Attacks
___Excessive Mucous Formation
___Back Dripping
___Nose Bleeding

Eyes

___Glasses/Contacts
___Watery or Itchy Eyes
___Red, Swollen or Sticky Eyelids
___Bags/Dark Circle Under Eyes
___Poor Vision
___Blurred or Tunnel Vision
_____Sensitive to Sunlight
___Eye Strain ___Bedwetting
___Eye Pain
___Red Eye
___Itchy Eyes
___Frequent or Urgent
___Considered/Attempted Suicide
___Wake to Urination
___Difficulty Completing Projects
___Genital Itch or Discharge
___Faintness
___Dizziness

___Insomnia, Sleep Disorder ___Facial Flushing ___Increased Libido
___Facial Pain
___Difficulty Making Decisions

Mouth & Throat
___Chronic Coughing
___Gagging, Often Clearing Throat
___Sore Throat, Hoarse, Voice Loss
___Swollen/Discolored Tongue/Lips
___Sores on Lips or Tongue ___Canker Sores
___Itching on Roof of Mouth ___Dry Mouth
___Excessive Saliva
___Recurrent Sore Throat ___Excessive Phlegm
Color: _____ ___Swollen Glands
___Lumps in Throat
___Enlarged Thyroid ___Teeth Problem ___Gum Problem
___Grinding Teeth

Skin & Hair ___Acne
___Itching ___Hives ___Rash
___Eczema
___Dry Skin
___Ulcerations ___Hair Loss ___Dandruff
___Flushing or Hot Flashes
___Change in Hair/Skin Texture ___Loss in Pigmentation ___Fungal Infections ___Scars

For Women Only
Age Menstrual Cycle Began:
_____
Length of Cycle (Day 1 - Day 1):
_____
Duration of Flow: _____ ___Dark Color Flow ___Clots in Flow
___Excessive Flow ___Irregular Circle ___Painful Period
___Excessive Vaginal Discharge ___Menopause Symptoms ___Lump in Breast
___Vaginal Dryness ___Vaginal Sores ___Vaginal Odor Vaginal Discharge Color:
_____ # of Pregnancies: _____
# of Live Births: _____
# of Premature Births: ____ Age at Menopause: _____ Date of Last PAP: _____ Date Last Period Began: _____ **Any Other Symptoms:**

_____
_____

17. Operations and Procedures

Date		**Date**		**Date**		
_____	Vaccinations	_____	Tubes in Ears	_____	Sinus	**Other:** _____
_____	Tonsillectomy	_____	Appendectomy	_____	Hernia	**Date:** _____
_____	Gall Bladder	_____	Female Organs	_____	Thyroid	
_____	Back Operation	_____	Rectal Surgery	_____	Stomach	

List and date any accidents or falls (please check):
[ ] Car _____, [ ] Recreation _____, [ ] Sports _____, [ ] School _____, [ ] Other _____
List any broken bones: _____
Have you ever had spinal taps or spinal injections (please circle)? Yes No Date:
_____
Have you ever lost consciousness (please circle)? Yes No Why?
_____ Have you ever had X-ray taken? Yes No Date:
_____ By Whom? _____
For what ailment were these X-rays taken?
_____
Do you suffer from any condition other than that for which you are now consulting us?
_____

I understand and agree that health and accident insurance policies are an arrangement between the insurance company and me. The heath care provider's office will prepare necessary paperwork to assist me in the filling insurance claims but cannot guarantee reimbursement. Direct payments made from the insurance company to the health care provider's office will be credited to my account upon receipt and any balances due will be my responsibility. All services rendered to me are my personal responsibility and I agree to make payments for these services to the health care provider's office. I also understand that if I suspend or terminate my care and treatment, any fees for services rendered will be immediately due and payable. Should third party collection become necessary, I agree to pay all fees involved in collections of the account.

I authorize the health care provider to examine and treat my condition as deemed appropriate through the use of chiropractic care, acupuncture, Traditional Chinese Medicine, and/or other natural healing methods.

Patient's / Guardian's Signature: _____ Date: _____