

GENERAL HEALTH HISTORY

Patient Name _____ *Mark the conditions that apply to you.*

Past	Present		Past	Present
☐	☐ Headaches		☐	☐ Urinary Problems
☐	☐ Migraines		☐	☐ Easy Bruising
☐	☐ Shortness of Breath		☐	☐ Tobacco Use
☐	☐ Allergies / Asthma		☐	☐ Dental Problems
☐	☐ Medication Side Effects		☐	☐ Fibromyalgia
☐	☐ Diabetes		☐	☐ Blood Thinner use
☐	☐ Hands or Feet cold		☐	☐ HIV Positive
☐	☐ Muscle aches		☐	☐ ☐ Cancer
☐	☐ Trouble Walking		☐	☐ Depression
☐	☐ Leg / Foot Numbness		☐	☐ ☐ Alcohol Use
☐	☐ Fainting		☐	☐ ___ High or ___ Low Blood Pressure
☐	☐ Gall Bladder Trouble		☐	☐ ☐ Stroke History
☐	☐ Ringing in Ears		☐	☐ High Cholesterol
☐	☐ Ear Problems		☐	☐ TMJ
☐	☐ Sleeping Problems		☐	☐ Digestive Problems
☐	☐ Vision Problems		☐	☐ Pain all Over
☐	☐ Thyroid Problems		☐	☐ Tension / Irritability
☐	☐ Liver Disease		☐	☐ ☐ Chest Pains
☐	☐ Kidney Problems		☐	☐ Heart Pacemaker
☐	☐ Light Bothers Eyes		☐	☐ Heart Problems
☐	☐ Other _____			

1. List any medications you are 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 _____

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:

Father's side: ☐ Heart Disease ☐ Cancer ☐ Diabetes ☐ Heavy Medication use ☐ Arthritis ☐

Other _____

Mother's side: ☐ Heart Disease ☐ Cancer ☐ Diabetes ☐ Heavy Medication use ☐ Arthritis ☐