Health History

Name: _____ Birthday: _____ Age: ____ Today's Date: _____

Address: _____ City & State:_____ Zip: _____

Phone:_____Email:_____

Social Security #:_____ Male____Female____Single_____Married____Divorced_____

Occupation:_____ Employer:_____ Spouses Name:_____

Number of Children:_____ Whom may we thank for referring you to our office? _____

Have you seen a Chiropractor before? Yes No If Yes, when? _____

Your Health Summary

Past	Current		Past	Current		Past	Current	
☐	☐	Headaches	☐	☐	Neck stiffness	☐	☐	Stomach Upset
☐	☐	Pins & needles arms	☐	☐	Constipation	☐	☐	Tension
☐	☐	Dizziness	☐	☐	Light sensitivity	☐	☐	Sports Injury
☐	☐	Numbness in fingers	☐	☐	Menstrual pain	☐	☐	Auto Accident
☐	☐	Fatigue	☐	☐	Menstrual irregularity	☐	☐	Weight Trouble
☐	☐	Sleeping problems	☐	☐	Fainting	☐	☐	Heartburn
☐	☐	Diarrhea	☐	☐	Back pain	☐	☐	Ulcers
☐	☐	Cold Sweats	☐	☐	Ringing in ears	☐	☐	Anxiety
☐	☐	Mood swings	☐	☐	Irritability	☐	☐	Diabetes
☐	☐	Pins and needles legs	☐	☐	Cold Hands/Feet	☐	☐	High Blood Pressure
☐	☐	Loss of smell/taste	☐	☐	Fever	☐	☐	Hot Flashes
☐	☐	Buzzing in ears	☐	☐	Problems urinating	☐	☐	Other:_____
☐	☐	Numbness in toes	☐	☐	Neck pain	☐	☐	_____
☐	☐	Depression	☐	☐	Loss of balance	☐	☐	_____
☐	☐	TMJ Disorder	☐	☐	Nervousness	☐	☐	_____
☐	☐	Migraines	☐	☐	Indigestion	☐	☐	_____

List any medications you are taking: _____

_____

On a scale of 1-10 with 10 being perfect health, my health today is a _____/10. I would like it to be a _____/10.

Is there anything else you would like to inform the doctor about?

_____

_____

_____

_____

_____

Media: Some parts of your visits may be monitored with photography, video, or audio recordings. Please initial to indicate that you have been made aware.

_____(Please Signature)