



HEALTH INFORMATION

Name _____ Date _____

Health Objective

Most patients that come to our office have one or two objectives in mind concerning their health care. Some come for symptomatic relief of pain or discomfort (Relief Care), others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). Your practitioner will weigh your needs and desires when recommending a treatment program.

Please check the type of care desired so that we may be guided by your wishes.

- Relief Care Corrective Care I would like the Practitioners assistance in selecting care

Areas of Concern & Health History

What are you main concerns, problems or pain? _____

What other health care have you received for this problem? _____

Results? _____

Was this caused by an accident? No Yes If yes Date of Accident _____
Type of Accident Auto Work Home Fall Other _____

Was this caused by an illness? No Yes If yes Date of Illness _____

Describe the Circumstances (Complete auto accident sheet if appropriate)

Drugs you now take Pain Killers/Muscle Relaxers Other _____

Have you lost time from work? No Yes If yes dates _____

If female are you pregnant? No Yes N/A Allergies _____

Do you suffer from any condition other than that which you now consulting us? _____

Major Surgeries and Dates _____
Major Accidents or Falls and Dates _____
Hospitalization (Other than Above) _____

Previous Care Chiropractic Massage Acupuncture MD Other _____
Approximate Date _____

Please check all that apply

Musculo-Skeletal

- Lower Back Pain
- Mid Back Pain
- Neck Problems
- Shoulder Problems
- Arm Problems
- Elbow Problems
- Wrist Problems
- Hand Problems
- Leg Problems
- Hip Problems
- Knee Problems
- Ankle Problems
- Feet Problems
- Swollen Joints
- Stiff Joints
- Sore Muscles
- Weak Muscles
- Walking Problems
- Broken Bones
- Sprains
- Numbness
- Arthritis
- Fibromyalgia
- Rheumatism
- Headaches/Migraines
- Osteoporosis
- Tendonitis
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Genito-Urinary System

- Bladder Troubles
- Excessive Urination
- Scanty Urination
- Painful Urination
- Discolored Urination
- Kidney Problems
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Cardio-Vascular-

Respiratory

- Chest Pains
- Difficulty Breathing
- Persistent Cough
- Coughing Phlegm
- Coughing Blood
- Rapid Heartbeat
- Blood Pressure Problems
- Heart Problems
- Lung Problems
- Varicose Veins
- Blood Clots
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Reproductive System

- Vaginal discharge
- Vaginal bleeding
- Vaginal pain
- Breast pain
- Lumps on Breast
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Gastro-Intestinal System

- Poor appetite
- Excessive hunger
- Difficulty chewing
- Difficulty swallow
- Excessive thirst
- Nausea
- Vomiting food
- Vomiting blood
- Abdominal pain
- Diarrhea
- Constipation
- Black-Bloody stool
- Hemorrhoids
- Liver problems
- Gall Bladder
- Weight trouble
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Eye, Ear, Nose & Throat

- Contacts
- Eye strain
- Eye inflammation
- Vision problems
- Ear pain
- Ear noise
- Hearing loss
- Ear discharge
- Nose pain
- Nose bleeding
- Nose discharge
- Difficult breathing thru nose
- Sore gums
- Dental problems
- Sore mouth
- Hoarseness
- Difficult speech

Nervous System

- Numbness
- Paralysis
- Dizziness
- Fainting
- Headaches
- Muscle jerking
- Convulsions
- Forgetfulness
- Confusion
- Depression
- Anxiety attacks
- Claustrophobia
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Please mark your areas of pain on the figures shown below

