# Health History

Name_____ B/D:_____ Date_____
Address: _____
Phone: Home_____ Cell: _____ Work: _____
Place of Employment: _____ S.S.#_____
Occupation_____ Age_____ Height_____ Sex_____ No. of children___
Who referred you to my office_____
Insurance Release: I hereby authorize Comprehensive Chiropractic Clinic, P.C. to furnish information to insurance carriers concerning my illness, injury or treatment and hereby assign to the physician all payments for medical services rendered. I understand that I am responsible for all charges, even those not paid by insurance. Signature_____ Date_____

**Reason for office visit**: Date began:

_____
_____
_____
If an injury, date and how it happened_____
_____
Describe the type of sensation: pins & needles swelling dizziness loss of sensation

If pain, what type of pain: lancing, sharp, dull, achy, does it travel? ___ If yes, location_____

Rate pain 0-10, 10 being the worst _____

Have you had previous treatment for this condition? _____ If so, what was it? _____
_____
_____What was the outcome? _____
List current health problems_____
_____
_____
Medication: _____
_____
Have you had X-Rays, an MRI or a CT? _____

Major Hospitalizations, Surgeries, Injuries:

| Year | Surgery, Illness, Injury | Outcome |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Circle the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest)
1 2 3 4 5 6 7 8 9 10
Identify the major causes of stress _____

Do you consider yourself underweight ___ overweight ___ just right ___
Have you had an unintentional weight loss or gain of 10 lbs or more in the last three months? _____

Is your job associated with potentially harmful chemicals (e.g., pesticides, radioactivity, solvents):
_____

## Medical History / Past and Present

**(Please circle all that apply)** Recent weight changes, fatigue, weakness, rashes, itching, headaches, head injury, dizziness, light-headedness, glasses, excess tearing, double vision, blurred vision, hearing problems, ringing in ears, vertigo, earaches, hoarseness, bleeding gums, cough, asthma, emphysema, high blood pressure, heart trouble, trouble swallowing, heartburn, nausea, constipation, diarrhea, belching, gas, hepatitis, muscle or joint pain, stiffness, arthritis, fainting, seizures, weakness, numbness, loss of sensation, pins & needles, tremors, thyroid trouble, excessive sweating, diabetes, nervousness, mood changes, depression, memory loss.

**Medical (Women):** Menstrual irregularities, endometriosis, infertility, fibrocystic breasts, fibro/ovarian cysts, premenstrual syndrome (PMS).

**Family Health History**: (Please indicate which family member)
Arthritis _____ Asthma _____ Alcoholism _____ Alzheimer's disease_____
Cancer _____ Depression _____ Diabetes _____Genetic disorder _____
Heart disease _____ Mental illness _____ Migraine headaches _____
Neurological disorders (Parkinson's. paralysis) _____ Obesity _____ Osteoporosis _____
Stroke _____ Suicide _____ Other _____

**Health Habits**: (per day) Tobacco_____ Alcohol _____ Coffee_____ Tea_____ Soda_____ Water_____

**Exercise:** 5-7 days per wk. 3-4 days per wk. 1-2 days per wk. none

**Eating habits**: Skip meals 1 meal /day 2 meals/ day 3 meals/day Graze (small frequent meals)
Generally eat on the run Eat constantly whether hungry or not

**Current Supplements**: _____

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