



**Past Health History**

List any major surgeries or operations you have had

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List any major falls, accidents or hospitalizations

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Have you seen a chiropractor before? Yes  No

If yes, Doctor seen \_\_\_\_\_ Last Visit \_\_\_\_\_

Below is a list of diseases and illnesses which may seem unrelated to the purpose of your visit, however, these questions must be answered carefully as these problems can affect the overall course of your care—

Please check any that may apply to you:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Pneumonia       | <input type="checkbox"/> Mumps            | <input type="checkbox"/> Influenza     |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Eczema           | <input type="checkbox"/> Lumbago       |
| <input type="checkbox"/> Polio           | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Pleurisy      |
| <input type="checkbox"/> Tuberculosis    | <input type="checkbox"/> Epilepsy         | <input type="checkbox"/> Arthritis     |
| <input type="checkbox"/> Whooping Cough  | <input type="checkbox"/> Thyroid          | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Anemia          | <input type="checkbox"/> Cancer           | <input type="checkbox"/> Diabetes      |
| <input type="checkbox"/> Measles         | <input type="checkbox"/> Chicken Pox      | <input type="checkbox"/> Small Pox     |

Please check all that apply to you within the last 6 months:

Muscular Skeletal

- Low Back Pain
- Pain between shoulders
- Neck Pain
- Arm Pain
- General Stiffness
- Joint Pain/Stiffness
- Problems Walking
- Difficulty Chewing

Nervous System

- Nervous
- Numbness
- Paralysis
- Dizziness
- Forgetfulness
- Confusion
- Depression
- Fainting
- Convulsions
- Cold Extremities
- Stress

General

- Fatigue
- Allergies
- Loss of Sleep
- Fever
- Headaches

Gastro-Intestinal

- Poor Appetite
- Excessive Thirst
- Nausea/Vomiting
- Diarrhea
- Hemorrhoids

gastro cont'd

- Weight Problems
- Abdominal Cramps
- Heartburn
- Colitis
- Gall Bladder Problems

Cardio-Pulmonary

- Chest Pain
- Shortness of Breath
- Blood Pressure Problems
- Irregular Heartbeat
- Heart Problems
- Lung Problems
- Varicose Veins
- Ankle Swelling
- Stroke

E/E/N/T

- Vision Problems
- Dental Problems
- Sore Throat
- Earaches
- Hearing Difficulty
- Stuffed Nose/Sinuses

Male/Female System

- Menstrual Irregular
- Menstrual Cramps
- Vaginal Pain/Infection
- Breast Pain/Lumps

Last Period? \_\_\_\_\_

Are you pregnant? \_\_\_\_\_

- Prostate Problems
- Impotent

Please include any other relevant data you would like to communicate to the doctor

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I hereby authorize the doctor to treat my condition as he or she deems appropriate. It is understood and agreed the amount paid to the doctor, for X-rays is for examination only and the X-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. I also agree that I am responsible for all bills incurred at this office.

Patient's Name \_\_\_\_\_  
Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Consent to Treat a Minor \_\_\_\_\_  
Parent or Legal Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_