Health History Form

Date

Full Name

Street Address

City

State

Zip

Email

Age

Birthdate

Marital Status

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Children

Work Phone

Home Phone

Cell

How did you find us?

Patient Referral

Google Search

Other Search (Yahoo, Bing, etc.)

Facebook

What is the main problem you would like to address?:

How long has it been since you first noticed any symptoms?:

Have you been referred to or given a diagnosis by an MD or chiropractor?:

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Falls/Accidents - related to incident and as far back as you can remember. Have you experienced any major accidents or significant trauma (physical or emotional)?:

Present Therapies - Are you seeing another practitoner?:

Past Therapies:

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To what extent does your problem affect your daily activities - work, sleep, play, eating, etc.?:

Past Medical History - anything you think might be pertinent:

Past Surgical History - when, for what reason?:

Dental History - orthodontics, TMJ, extractions, other:

List prescription medications (and recreational drugs):

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List over the counter medications and vitamins, herbs, supplements:

Food Allergies?:

Heading

Work Stress factors

How long is your commute?:

How many hours a week do you work?:

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How many hours a day do you work at a computer?:

Are there other physical, psychological, chemical stressors at work?:

Do you enjoy your work? If not why?:

Heading

Lifestyle

Do you follow a regular exercise program? Describe:

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Do you wear orthotics?:

Do you eat 3 meals a day?:

If not, how many?:

Describe your diet:

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Coffee, tea, caffeinated soft drinks - cups per day:

Tobacco - packs per day?:

Heading

Sleep Patterns

How many hours do you sleep each night?:

If you get up, do you fall back asleep without a problem?:

Do you wake up rested?:

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Do you wake up with stiffness? If so, where?:

Support network - what resources do you have in your life? (person, place, animal):

Emotional factors - anxiety, mood swings, depression:

Energy - Fatigue, chronic infections, chronic fatigue:

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Heading

Family History

Birth order:

Siblings:

Any major illnesses in family history - Cancer, diabetes, high blood pressure, stroke, mental illness, allergies:

Childhood Illnesses - hospitalizations, ear infections, respiratory problems, phobias, any knowledge of birth history:

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Allergies:

Other general symptoms - headaches, chills, dizziness, nervousness, numbness/pain in arms, hands, legs, depression, tinnitus, digestive, urinary, hormonal:

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