



PERSONAL HEALTH HISTORY

Patient's Name _____ DOB _____ Date _____

All information will be kept strictly confidential. Your responses will help determine if chiropractic treatment will benefit you. Unless we sincerely feel that your condition will respond satisfactorily, we will not recommend treatment. Please check the degree of all conditions you currently have or have had. To be responsible for your case, we need your complete health history.

O = Occasional F = Frequent C = Constant

**O F C
Muscle / Joint**

- Arthritis
- Bursitis
- Foot trouble
- Hernia
- Low back pain
- Lumbago
- Neck pain, stiffness
- Pain between shoulders

General

- Allergy
- Chills
- Convulsions
- Dizziness
- Fainting
- Fatigue
- Fever
- Headache
- Loss of sleep
- Loss of weight
- Nervousness, depression
- Neuralgia
- Numbness
- Sweats
- Tremors

Cardiovascular

- Hardening of arteries
- High blood pressure
- Low blood pressure
- Pain over heart
- Poor circulation
- Rapid heartbeat
- Slow heartbeat
- Swelling of ankles

Genitourinary

- Bed-wetting
- Blood in urine
- Frequent urination
- Lack of kidney control
- Kidney infection
- Painful urination
- Prostate trouble
- Pus in urine

O F C

Eye, Ear, Nose and Throat

- Asthma
- Colds
- Crossed eyes
- Deafness
- Dental decay
- Earache
- Ear discharge
- Ear noise
- Enlarged glands
- Enlarged thyroid
- Eye pain
- Failing vision
- Far sightedness
- Gum trouble
- Hay fever
- Hoarseness
- Nasal obstruction
- Near sightedness
- Nose bleeds
- Sinus infection
- Sore throat
- Tonsillitis

Gastrointestinal

- Belching or gas
- Colitis
- Colon trouble
- Constipation
- Diarrhea
- Difficult digestion
- Bloated abdomen
- Excessive hunger
- Gallbladder trouble
- Hemorrhoids
- Intestinal worms
- Jaundice
- Liver trouble
- Nausea
- Pain over stomach
- Poor appetite
- Vomiting
- Vomiting of blood

O F C

Skin

- Boils
- Bruise easily
- Dryness
- Hives or allergy
- Itching
- Skin eruptions (rash)
- Varicose veins

Pain or numbness in

- Shoulders
- Arms
- Elbows
- Hand
- Hips
- Legs
- Knees
- Feet
- Painful tailbone
- Poor posture
- Sciatica
- Spinal curvature
- Swollen joints

Respiratory

- Chest pain
- Chronic cough
- Difficult breathing
- Spitting up blood
- Spitting up phlegm
- Wheezing

Women only

- Congested breasts
- Cramps or backache
- Excess menstrual flow
- Hot flashes
- Irregular cycle
- Lumps in breast
- Menopause
- Painful menstruation
- Vaginal discharge

Are you pregnant? Yes No
If yes, how many months? _____
How many children do you have? _____

Check any of the following conditions you currently have or have had:

- Alcoholism
- Anemia
- Appendicitis
- Arteriosclerosis
- Cancer
- Chicken pox
- Cholera
- Cold sores
- Diabetes
- Diphtheria
- Eczema
- Edema
- Emphysema
- Epilepsy
- Fever blisters
- Goiter
- Gout
- Heart disease
- Herpes
- Influenza
- Lumbago
- Malaria
- Measles
- Miscarriage
- Multiple sclerosis
- Mumps
- Pacemaker
- Pleurisy
- Pneumonia
- Polio
- Rheumatic fever
- Scarlet fever
- Stroke
- Tuberculosis
- Typhoid fever
- Ulcers
- Venereal disease
- Whooping cough

Describe chiropractic problem: _____

How long have you had this condition?	Is it getting worse? <input type="checkbox"/> Yes <input type="checkbox"/> No
Does it bother your (check appropriate box): <input type="checkbox"/> Work <input type="checkbox"/> Sleep <input type="checkbox"/> Other (please specify)	
What seemed to be the initial cause?	
Have you seen a chiropractor before? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how long ago? _____	
For what reason?	
Are you under the care of a physician? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, for what reason?	



ADVANCED CHIROPRACTIC CENTER

6035 Greenback Ln. Citrus Heights, CA 95621

Ph: (916) 580-3277 Fax: (916) 307-5166

Patient's Name _____ DOB _____ Date _____

Have you been hospitalized in the last 5 years? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, for major surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No	for serious injury? <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you had any mental or emotional disorders? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when?		
Indicate the drugs do you now take? <input type="checkbox"/> Birth control pills <input type="checkbox"/> Tranquilizers <input type="checkbox"/> Pain Killers <input type="checkbox"/> Other (specify)		
Do you wear: <input type="checkbox"/> heel lifts? <input type="checkbox"/> sole lifts? <input type="checkbox"/> inner soles? <input type="checkbox"/> area supports? <input type="checkbox"/> negative heels? <input type="checkbox"/> platform shoes?		
What is the age of your mattress? _____ Is it <input type="checkbox"/> comfortable? <input type="checkbox"/> uncomfortable? Do you use a bedboard? <input type="checkbox"/> Yes <input type="checkbox"/> No		
How is most of your day spent? <input type="checkbox"/> standing <input type="checkbox"/> sitting <input type="checkbox"/> walking <input type="checkbox"/> other (specify)		

Have you ever:	Yes	No	If yes, briefly explain.
- had a broken bone?	<input type="checkbox"/>	<input type="checkbox"/>	
- been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	
- had strains or sprains?	<input type="checkbox"/>	<input type="checkbox"/>	
- used a cane, crutch or other support?	<input type="checkbox"/>	<input type="checkbox"/>	
- been struck unconscious?	<input type="checkbox"/>	<input type="checkbox"/>	
- been hospitalized for other than surgery?	<input type="checkbox"/>	<input type="checkbox"/>	

Do you:	Yes	No
- take minerals, herbs or vitamins?	<input type="checkbox"/>	<input type="checkbox"/>
- think you need minerals, herbs or vitamins?	<input type="checkbox"/>	<input type="checkbox"/>
- have any drug allergy?	<input type="checkbox"/>	<input type="checkbox"/>

When did you last have:	Never	0-6 mos.	6 -18 mos.	longer
- spinal x-ray?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- spinal examination?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- physical examination?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

HABITS	None	Light	Mod	Heavy
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Soft Drinks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Salty Foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sugar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Sweeteners	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please list any other health conditions you have been treated for, or surgery you have had in the last ten years.

FAMILY HEALTH HISTORY: Information about your immediate family members, brothers, sisters, parents, and grandparents will give us a better understanding of your total health picture.

RELATIONSHIP	PRESENT AND PAST HEALTH PROBLEMS

Please mark your areas of pain on the figures below.