HEALTH HISTORY QUESTIONNAIRE

Date: ____________________

NAME: ____ PHONE: H-______________ W-______________
ADDRESS: ______________________________ CITY: ______________ STATE: _____ ZIP: ________
AGE: _____ DATE OF BIRTH: ______________ PLACE OF BIRTH: ____________________
HEIGHT: _____ WEIGHT: ______ MARITAL STATUS: ______ SOCIAL SECURITY # ____________
OCCUPATION: ____
EMPLOYER NAME & ADDRESS: ____
FAMILY PHYSICIAN: ______________________________ REFERRED BY: ______________________
IN EMERGENCY, NOTIFY: ______________________________ PHONE #: ____________________
HAVE YOU BEEN TREATED BY MANIPULATION BEFORE? ___ YES
___ NO

Main problem(s) you would like us to help you with: ____

____

____

How long ago did this problem begin (be specific): ____

____

____

To what extent does this problem interfere with your daily activities (work, sleep, sex, etc): ______________________

____

____

Have you been given a diagnosis for this problem? If so, what? ________________________________

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____

What kinds of treatment have you tried? ____

____

____

Past Medical History (please include date): Cancer _____ Diabetes _____ Hepatitis _____ High Blood Pressure _____
Heart Disease _____ Rheumatic Fever _____ Thyroid Disease _____ Seizures _____ Venereal Disease _____
Other ____

____

Surgeries (type of and date) ____

____

Significant Trauma (auto accidents, falls, etc.): ____

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Significant Dental Work (type and date): ______________________________

Birth History (prolonged labor, forceps delivery, etc) ______________________________

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Allergies (drugs, chemicals, foods/result): ______________________________

____

Family Medical History (check): Diabetes___ Cancer___ High Blood Pressure___ Heart Disease___
Stroke___Seizures___ Asthma___ Allergies___
Other ______________________________

Medicines taken within the last two months (vitamins, drugs, herbs, etc.): ______________________________

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Occupational Stress (chemical, physical, psychological, etc.): ______________________________

____

Do you have a regular exercise program? Yes___ No___ Please describe: ______________________________

____

Have you ever been on a restricted diet? Yes___ No___ What kind? ______________________________

____

Please describe your average daily diet:

MORNING: ______________________________

AFTERNOON: ______________________________

EVENING: ______________________________

How many packs of cigarettes do you smoke per day? ______________________________

How much coffee, tea or cola do you drink per week? ______________________________

How much alcohol do you drink per week? ______________________________

Please describe any use of drugs for non-medical purposes: ______________________________

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Please check any you have had in the last three months:

GENERAL:

__ Poor appetite
__ Fevers
__ Sweat easily
__ Localized weakness
__ Bleed or bruise easily
__ Peculiar tastes or smells
__ Strong thirst (cold or hot)
__ Thirst, no desire to drink

__ Sudden energy drop - what time of day?___
__ Poor sleeping
__ Chills
__ Tremors
__ Poor balance
__ Fatigue
__ Night sweats

__ Cravings
__ Change in appetite
__ Weight gain
__ Weight loss

SKIN & HAIR:

__ Rashes
__ Itching

__ Dandruff
__ Change in hair or skin
__ Ulcerations
__ Eczema
__ Loss of hair
__ Hives
__ Pimples
__ Recent moles

__ Other hair or skin problems: ______________________________

HEAD, EYES, EARS, NOSE AND THROAT:

__ Dizziness
__ Glasses
__ Poor vision
__ Cataracts
__ Ringing in ears
__ Sinus problems
__ Grinding teeth
__ Teeth problems
__ Concussions
__ Eye strain
__ Night blindness
__ Blurry vision
__ Poor hearing
__ Nose bleeds
__ Facial pain
__ Jaw clicks
__ Migraines
__ Eye pain
__ Color blindness
__ Earaches
__ Spots in front of eyes
__ Recurrent sore throat
__ Sores on lips or tongue
__ Headaches: Where and when: ________________

____

__ Other head or neck problems: ________________

____

CARDIOVASCULAR:

__ High blood pressure
__ Irregular heartbeat
__ Cold hands or feet
__ Blood clots
__ Low blood pressure
__ Dizziness
__ Swelling of hands
__ Phlebitis
__ Chest pain
__ Fainting
__ Swelling of feet
__ Difficulty in breathing
__ Other heart or blood vessel problems: ________________

____

RESPIRATORY:

__ Cough
__ Bronchitis
__ Difficulty in breathing when lying down
__ Production of phlegm: what color: ________________
__ Coughing blood
__ Pneumonia
__ Asthma
__ Pain with a deep breath
__ Other lung problems: ________________

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GASTROINTESTINAL:

__ Nausea
__ Constipation
__ Black stools
__ Bad breath
__ Abdominal pain or cramps
__ Chronic laxative use
__ Vomiting
__ Gas
__ Blood in stools
__ Rectal pain
__ Diarrhea
__ Belching
__ Indigestion
__ Hemorrhoids
__ Other stomach or intestinal problems:

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GENITO-URINARY:

__ Pain on urination
__ Urgency to urinate
__ Decrease in flow
__ Frequent urination
__ Unable to hold urine
__ Impotency
__ Blood in urine
__ Kidney stones
__ Sores on genitals
__ Other genital or urinary system problems:

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Do you wake up to urinate?
__ Yes __ No How often? ________________
Any particular color to your urine? ________

PREGNANCY & GYNECOLOGY:

Number of pregnancies: ________
Number of births: ________
Premature births: ________
Miscarriages: ________
Abortions: ________
Age at first menses: ________
Period between menses: ________
Duration: ________
First date of last menses: ________
__ Unusual character (heavy or light)
__ Painful periods
__ Vaginal discharge
__ Changes in body/psyche prior to menstruation
__ Clots
__ Vaginal sores
__ Irregular periods

Last pap: ________________
__ Breast lumps
Do you practice birth control?
__ Yes __ No
What type and how long?

____

MUSCULOSKELETAL:

__ Neck pain
__ Back pain
__ Hand/wrist pains
__ Muscle pains
__ Muscle weakness
__ Shoulder pain
__ Knee pain
__ Foot/ankle pains
__ Hip pain

NEUROPSYCHOLOGICAL:

__ Seizures
__ Areas of numbness
__ Concussion
__ Bad temper
__ Dizziness
__ Lack of coordination
__ Depression
__ Easily susceptible to stress
__ Loss of balance
__ Poor memory
__ Anxiety
__ Other neurological or psychological problems: ________

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Please note the degree of severity of your problem now:

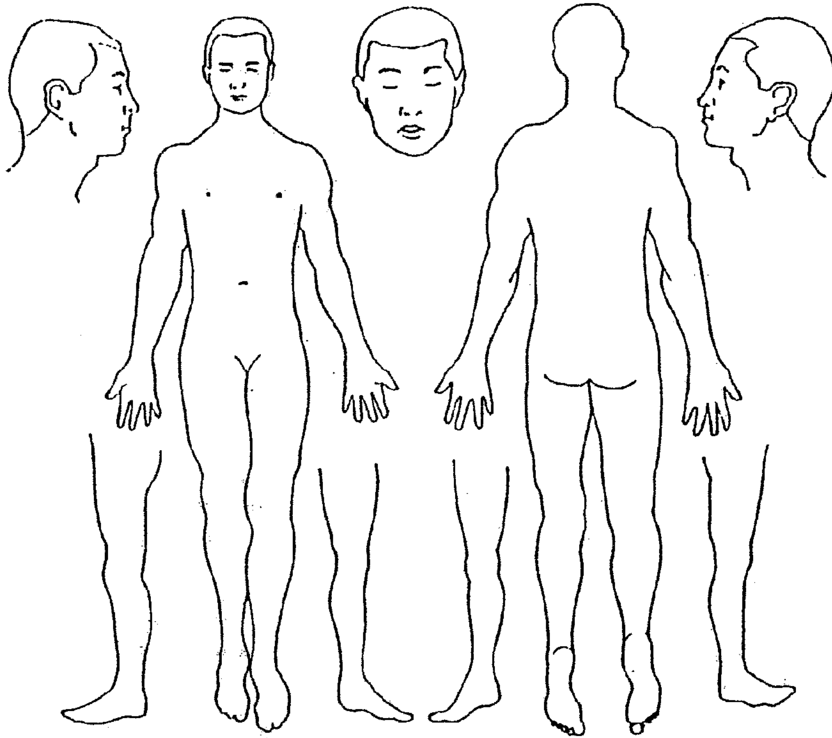
NO PROBLEM ———————————————————————————— WORST IMAGINABLE

Please note the greatest degree of severity of your problem within the last week:

NO PROBLEM ———————————————————————————— WORST IMAGINABLE

Indicate painful or distressed areas:

Symbol	Reaction
Pain on Pressure	
x	little
xx	moderate
xxx	strong
Swelling	
∩	slight
∩∩	moderate
∩∩∩	strong
Tension/Weakness	
U	weak
	normal
#	tense
Spontaneous Pain	
↑	slight
↑↑	moderate
↑↑↑	severe
Pulsing	
•	slight
••	moderate
•••	strong
Temperature	
↓	colder
	normal
↑	hotter
Physical	
O	sores
↑↑	rashes
→ ←	spasms



COMMENTS (please tell us any other problems you would like to discuss): ____________________

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