HEALTH HISTORY

Please check if you are currently experiencing any of the following conditions:

❑ Neck Pain/Stiffness
❑ Back Pain/Stiffness
❑ Arm/Hand Pain
❑ Leg/Knee Pain
❑ Headaches
❑ Dizziness
❑ Asthma
❑ Pins/Needles in Arms
☐ Pins/Needles in Legs
❑ Fatigue
❑ Sleeping Difficulties
❑ Loss of Smell
❑ Allergies
❑ Blurred Vision
❑ Light Bothers Eyes
❑ Depression
❑ Nervousness
❑ Tension
❑ Cold Sweats
❑ Stomach Problems
❑ Night Pain
❑ Sudden Weight Loss
❑ Loss of Taste
❑ Loss of Memory
❑ Jaw Problems
❑ Constipation
❑ Shortness of Breath
❑ Bowel/Bladder Changes
❑ Nausea
❑ Cold Feet
❑ Chest Pain
❑ Fever
❑ Fainting

Please check if you are "having now or have had in the past " any of the following:

☐ Aids/HIV
☐ Alcoholism
☐ Allergy Shots
☐ Anemia
☐ Anorexia
☐ Appendicitis
☐ Arthritis
☐ Asthma
☐ Bleeding Disorder
☐ Breast Lump
☐ Bronchitis
☐ Bulimia
☐ Cancer
☐ Cataracts
☐ Chemical Dependency
☐ Chicken Pox
☐ Diabetes
☐ Emphysema
☐ Epilepsy
☐ Fractures
☐ Glaucoma
☐ Goiter
☐ Gonorrhea
☐ Gout
☐ Heart Disease
☐ Hepatitis
☐ Hernia
☐ Herniated Disc
☐ Herpes
☐ High Cholesterol
☐ High Blood Pressure
☐ Kidney Disease
☐ Liver Disease
☐ Measles
☐ Migraines
☐ Miscarriage
☐ Mononucleosis
☐ Multiple Sclerosis
☐ Mumps
☐ Osteoporosis
☐ Pacemaker
☐ Parkinson's Disease
☐ Pinched Nerve
☐ Pneumonia
☐ Polio
☐ Prostate Problems
☐ Prosthesis
☐ Psychiatric Care
☐ Rheumatoid Arthritis
☐ Rheumatic Fever
☐ Scarlet Fever
☐ Stroke
☐ Suicide Attempt
☐ Thyroid Problems
☐ Tonsillitis
☐ Tuberculosis
☐ Tumors/Growths
☐ Typhoid Fever
☐ Ulcers
☐ Vaginal Infections
☐ Venereal Disease
☐ Whooping Cough

____

Are you currently seeing a doctor for medical care and/or prescription medication? ☐yes ☐no

If yes, please explain what you are being treated for____

____.

Name of medical doctor:____Location:___________________________

Please list any medications you are currently taking:____

____

Please list any surgeries and/or hospitalizations you have had (type & date):___________________________

____

Please list any allergies including medication and food ____

____

Please list any supplements you are currently taking (vitamins/herbs/minerals):_________________________

____

Is there a family history of any of the following conditions? (indicate family member including parents, grandparents & siblings)

☐ Heart Disease_____________________________ ☐ Cancer_________________________

☐ Diabetes_________________________________ ☐ Arthritis________________________

Do you exercise? ☐ None ☐ Sometimes ☐ Moderately ☐ Frequently

Do your work duties mostly involve: ☐ Sitting ☐ Standing ☐ Light Labor ☐ Heavy Labor

How long have you been employed at your current job?_______________________

Do you sleep on your: ☐ Back ☐Side ☐Stomach Do you use a cervical pillow? ☐yes ☐no

What is your daily intake of the following:

Caffeine (coffee, tea)_____cups/day Alcohol_____drinks/day Cigarettes_____packs/day

HEIGHT_________ WEIGHT_________

I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.

PATIENT SIGNATURE_____________________________________DATE_______________

PARENT/GUARDIAN SIGNATURE____________________________DATE_______________