Health History

1. What is your MAJOR COMPLAINT today? ____
2. WHEN did this happen (**RECENT**)? ____
3. HOW did this happen (**RECENT**)? ____
4. Is the pain getting better, worse, or staying the same? ____
5. Is the pain stopping you from doing any of your normal daily activities? YES NO If yes, please describe:
   ____
6. Are you pregnant or trying to get pregnant? YES NO How far along? ______________________________
7. Have you had this pain/discomfort before? If yes, what treatment did you get? :
   ____
8. Is the pain CONSTANT FREQUENT or does it COME AND GO?
9. Does the pain radiate? YES NO If yes, where? Arm R/L Hand R/L Buttock R/L Leg R/L Foot R/L
10. WHEN is the pain worse: Morning Afternoon Evening Sleeping As day progresses No change
11. WHAT makes the pain worse? Walking Standing Sitting Bending Lifting Trying to stand up Driving Work Sports Sleeping Coughing Sneezing Laughing Other:____
12. WHEN is the pain better: Morning Afternoon Evening Sleeping As day progresses No change
13. WHAT makes the pain BETTER? Ice Heat Stretches Sitting Lying Down Standing Walking Medication Chiropractic Other:____
14. Do you have any weakness in your arms legs hands? YES NO
15. Do you have any recent changes in your bowel or bladder? YES NO
16. Are you RIGHT or LEFT handed?
17. Height: ___ft ___in Weight: _____lbs
18. List any major SURGERIES, major ILLNESSES, TRAUMAS, or FRACTURES
    BODY PART:________________ DATE: __________ BODY PART:_____________ DATE:___________
    BODY PART: ________________ DATE: __________ BODY PART:_____________ DATE:___________
19. Please indicate illness on family history; Cancer, Diabetes, Stroke, Heart Condition, other:
    Mother: ________________________ Father: ___________________________
    Sister: __________________________ Brother: ___________________________
    Maternal Grandmother: ________________________ Maternal Grandfather: ______________________
    Paternal Grandmother: _________________________ Paternal Grandfather: ______________________
20. Marital Status: SINGLE MARRIED DIVORCED WIDOWED
21. Alcohol use: NONE CASUAL MODERATE HEAVY Type: BEER LIQUOR WINE
22. Caffeine use: NONE <3 CUPS/DAY 4-6 CUPS/DAY 6+ CUPS/DAY
23. Tobacco use: NONE FORMER SOCIALLY DAILY
24. Type of tobacco: SMOKE SMOKELESS VAPE
25. Exercise: NONE DAILY WEEKLY WALKS RUNS SWIMS WEIGHTS
26. Do you have any OTHER SYMPTOMS you would like to discuss at this time?
    ____

Patient Name: ____

Patient Signature: ____

Date: ____________________