Health History

Date: _____

Last Name: _____Middle_____First Name:_____

1) Primary reasons for seeking treatment: Please describe the location of complaint.

_____

_____

_____

2) Please circle the Quality of the complaint/pain: dull aching sharp shooting burning throbbing deep nagging

3) Does this complaint/pain radiate or travel (shoot) to any areas of your body? Where? _____

4) Do you have any numbness or tingling in your body? Where? _____

5) Grade Severity of your pain (0= No pain, 10= Worst Pain) 0 1 2 3 4 5 6 7 8 9 10

6) When did this situation or concern begin? _____

7) Why do you think this has happened or continues to happen to you? _____

8) How frequent is complaint present, how long does it last? _____

9) Does anything aggravate the complaint? _____

10) Does anything make the complaint better? _____

11) Have you done anything about this situation or concern or gotten any advice or treatment for it? Yes No

If yes, what were you told? _____

12) What was done? _____

13) Did that seem to work? _____

14) Please grade the level to which your complaint(s) affect these aspects of your functioning/quality of life.

0 - No effect	**1 - Slight effects**	**2 - Moderate effects**	**3 - Drastic effects**
Effects on work	0 1 2 3	Effects on recreation/play	0 1 2 3	Effects on rest/sleep	0 1 2 3
Effects on social life	0 1 2 3	Effects on walking	0 1 2 3	Effects on sitting	0 1 2 3
Effects on exercise	0 1 2 3	Effects on eating	0 1 2 3	Effects on love life	0 1 2 3

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1) Have you ever injured your spine (neck, head, back, hips)? Yes No

Please describe: _____

2) Have you had a work/motor vehicle accident related injury? Yes No

Please describe: _____

3) Please list medications (prescription or non-prescription) you have taken within the past 60 days: _____

_____

4) Have you had any spinal x-rays, CAT scans or MRI imaging of your spine or head? Yes No

If yes, when:_____

5) What were you told about them? _____

6) Have you had any surgeries? Please explain: _____

7) Have you broken any bones, or significantly sprained part of your body? Yes No

Please explain: _____

8) Please list any herbs, nutritional supplements or natural home remedies you take regularly:

_____

9) Do you have an exercise program or are you involved in any sports/recreational activity? Yes No

If yes, please describe:_____

Has your spine ever been adjusted by a Chiropractor? Yes No

a) By whom and when? _____

b) Why did you go? _____

c) Was it a “manual” adjustment (did you hear or feel ‘cracking’)? Yes No

d) Did you like it? Yes No

How tall are you? _____ How much do you weigh?_____ Are you Right-Handed / Left-Handed? (circle one)

Do you sleep on your- Back / Left Side / Right Side / Stomach (circle one or more)

Write your additional comments here:

Do not write below this line
