

GENERAL HEALTH HISTORY

Check only those conditions that apply to you and indicate if you have had in the past or presently have:

YES	GENERAL QUESTIONS	PAST	PRESENT
<input type="checkbox"/>	I bruise easily	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	I heal slowly	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	My body temperature is normally low (feel cold)*	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Smoke cigarettes or use tobacco products	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Diabetic-Hypoglycemic or need to have dialysis.	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Do you have a pacemaker or any other mechanical/electronic device in your body?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Do you have difficulties or intolerance to heat packs or ice packs on your skin?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Dizziness, blacked out, or fainting spell history	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Epilepsy-Seizure-Convulsion history	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	History of gout, lupus, psoriasis, temporary paralysis, or spinal meningitis	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Cancer history or treatment of any type	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Stroke history (Indicate any suspected strokes or transient ischemic attacks)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Told that you have scoliosis, spondylolisthesis, disc degeneration, or herniated disc	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Told that you have spina bifida, abdominal aneurysm, or vascular conditions	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Have you ever been hospitalized? Why:	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Thyroid disorders	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Coma from head injury or other problem	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Told you have osteoporosis of your spine or osteopenia (weak bones)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Told you have osteoarthritis or rheumatoid arthritis of your spine or joints	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Women only: Check this box if you currently have any type of breast implants	N/A	N/A
<input type="checkbox"/>	Women only: Check this box if there any chance that you are currently pregnant	N/A	N/A

PRIOR INJURY OR MUSCULOSKELETAL PAIN HISTORY

I have no history of previous painful injury or pain) If you have had prior injuries or pain, please check below:

<input type="checkbox"/> Work Injury	<input type="checkbox"/> Fall	<input type="checkbox"/> Sports Injury	<input type="checkbox"/> Lifting Injury	<input type="checkbox"/> Car accident
<input type="checkbox"/> Motorcycle Injury	<input type="checkbox"/> Bicycle Injury	<input type="checkbox"/> Pedestrian Injury	<input type="checkbox"/> Military Injury	<input type="checkbox"/> Other
Injury				
<input type="checkbox"/> Headaches/Migraines	<input type="checkbox"/> Neck Pain or Arm Pain	<input type="checkbox"/> Middle Back Pain	<input type="checkbox"/> Low Back/Leg Pain	<input type="checkbox"/> Other Pain

FRACTURES/BROKEN BONES

I have never had any broken bones). If you have broken any bones, indicate where and when:

Region	Year	Region	Year
<input type="checkbox"/> Spinal Vertebra		<input type="checkbox"/> Skull	
<input type="checkbox"/> Collar bone (clavicle)		<input type="checkbox"/> Rib bone	
<input type="checkbox"/> Arm or hand bone		<input type="checkbox"/> Leg or foot bone	
<input type="checkbox"/> Pelvis bone		<input type="checkbox"/> Other	

PREVIOUS SURGERIES

I have never had any surgical procedure). If you have had any previous surgery, indicate type and when:

Surgery	Year	Surgery	Year
<input type="checkbox"/> Spine Surgery (neck or back)		<input type="checkbox"/> Appendix	
<input type="checkbox"/> Disc surgery in neck or back		<input type="checkbox"/> Gallbladder/Stomach/Kidney	
<input type="checkbox"/> Heart		<input type="checkbox"/> Cancer (any type)	
<input type="checkbox"/> Tonsillectomy		<input type="checkbox"/> Rib/Collar bone	
<input type="checkbox"/> Head/Brain		<input type="checkbox"/> Hernia	
<input type="checkbox"/> Shoulder/Arm/Leg		<input type="checkbox"/> Other	

GENERAL HEALTH HISTORY CONTINUED (Page 2)

LIST ALL SYMPTOM REGIONS AND HOW LONG YOU HAVE HAD THEM

CHECK ALL SYMPTOM AREAS	HOW LONG	CHECK ALL SYMPTOM AREAS	HOW LONG
<input type="checkbox"/> Headaches/Migraines		<input type="checkbox"/> Upper Back Pain, Soreness, or Stiffness	
<input type="checkbox"/> Neck Pain, Soreness, or Stiffness		<input type="checkbox"/> Hip Pain	
<input type="checkbox"/> Low Back Pain, Soreness, Stiffness		<input type="checkbox"/> Leg or Foot Pain, Numbness, or Tingling	
<input type="checkbox"/> Arm/Hand Pain, Numbness, or Tingling		<input type="checkbox"/> Other:	

Did your symptoms come on? Suddenly, Gradually

SYMPTOM/PAIN DESCRIPTION

Please circle any word or words below that best describes how your symptoms currently feel to you.

Pain	Pinching	Spreading	Vicious	Unbearable
Ache	Pricking	Shooting	Sickening	Soreness
Cutting	Tingling	Stabbing	Miserable	Pins and Needles
Tearing	Gnawing	Dull	Troublesome	Radiating
Crushing	Nagging	Bony	Pressing	Weakness
Pulling	Boring	Terrifying	Deep pain	Falls asleep
Irritating	Burning-Hot	Dreadful	Superficial pain	Suffocating
Annoying	Drill like	Fearful	Stinging	Punishing
Stiff or tight	Heavy	Unhappy	Throbbing	Crawling
Exhausting	Numbness	Torturing	Sharp	Tender

Have you ever been to a Chiropractor before for any condition?

No, Yes If yes, Chiropractors Name : _____

Year: _____ Problem seen for: _____

No, Yes Do you have any problems laying face down on an examination table? If yes, why: _____

ARE YOU TAKING ANY MEDICATIONS?

I am not taking any medications currently. Check any of the following that you are taking currently.

<input type="checkbox"/> Muscle Relaxants	<input type="checkbox"/> Aspirin	<input type="checkbox"/> Anacin
<input type="checkbox"/> Anti-inflammatory	<input type="checkbox"/> Tylenol	<input type="checkbox"/> Bufferin
<input type="checkbox"/> Narcotics for Pain	<input type="checkbox"/> Advil/Motrin	<input type="checkbox"/> Stroke prevention meds
<input type="checkbox"/> Heart medications	<input type="checkbox"/> Birth control medications	<input type="checkbox"/> Other

WHEN IS YOUR PAIN USUALLY BETTER?

<input type="checkbox"/> Morning	<input type="checkbox"/> Afternoon	<input type="checkbox"/> Evening
<input type="checkbox"/> During sleep hours	<input type="checkbox"/> Lying down flat	<input type="checkbox"/> Standing
<input type="checkbox"/> Walking	<input type="checkbox"/> Sitting	<input type="checkbox"/> Rest
<input type="checkbox"/> Stress (mental) is less	<input type="checkbox"/> Good posture	<input type="checkbox"/> Exercise/Stretching

HAS YOUR PAIN BEEN ASSOCIATED WITH:

<input type="checkbox"/> Excessive fatigue-malaise	<input type="checkbox"/> Bowel or bladder disorders	<input type="checkbox"/> Night pain or night time sweats
<input type="checkbox"/> Weight loss	<input type="checkbox"/> Ovarian pain	<input type="checkbox"/> Abdominal pain
<input type="checkbox"/> Low grade fever	<input type="checkbox"/> Kidney pain/painful urination	<input type="checkbox"/> Balance problems

DO YOU EXERCISE?

<input type="checkbox"/> I do no regular exercise	<input type="checkbox"/> I exercise 1-2 times a week	<input type="checkbox"/> I exercise 3-5 times a week
<input type="checkbox"/> I stretch regularly	<input type="checkbox"/> I do weight lifting at gym/home	<input type="checkbox"/> I do cardiovascular work outs
<input type="checkbox"/> I am willing to do exercise	<input type="checkbox"/> I am not willing to do exercises	<input type="checkbox"/> I do regular sports activities