

Chiropractic and Massage CONFIDENTIAL HEALTH HISTORY FORM



Name: _____ Date _____

Current Concerns? _____

How did this problem begin (eg. fall, lifting, etc.)? _____

How long have you had this condition? _____ Have you had this or similar conditions in the past? _____

What activities aggravate your condition? _____

What relieves your condition? _____

Other doctors who treated this condition: _____

How long has it been since you really felt good? _____

Other complaints: _____

List surgical operations and years: _____

Medications you currently take: _____

Vitamins/Supplements you currently take: _____

Sleeping position: ___Back ___Side ___Stomach Do you wear: ___Heel lifts ___Arch supports

Have you ever been in a motor vehicle accident? ___No ___Yes When? _____

Were you injured? ___No ___Yes

Describe: _____

Have you had any other personal injury or accident? ___No ___Yes When _____

Describe: _____

Is there a family history of: ___Heart Disease ___High Blood Pressure ___Stroke ___Cancer ___Arthritis

___Osteoporosis ___Diabetes Other: _____

If female, is there any possibility that you are pregnant? ___Yes ___No Do you have any children? ___No ___Yes

Date of last physical examination: ___/___/___ Dr: _____

Do you exercise? ___N ___Yes (what forms and how often) _____

Have you ever had chiropractic care? ___No ___Yes

Have you ever had massage before? ___No ___Yes

When? _____ Why? _____

Where? _____

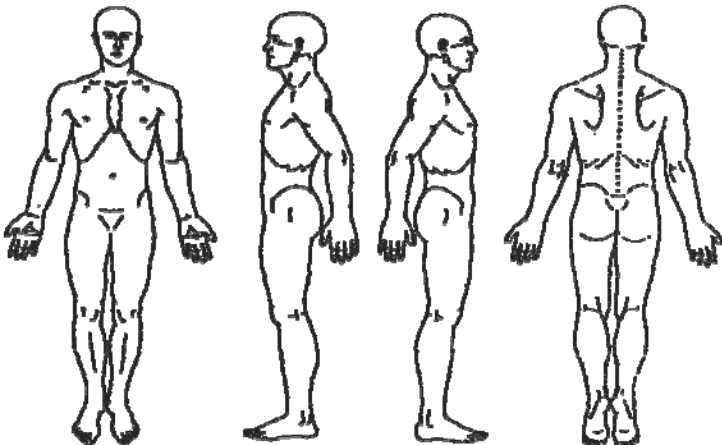
Were **X-rays** taken? ___Yes ___No **MRI** ___Yes ___No

When was your last adjustment? _____

When was your last massage? _____

Have you in the past or do you presently suffer from any of the following?

- _____ Dizziness
- _____ Back Pain
- _____ Numbness
- _____ Tingling
- _____ Weakness
- _____ Muscle Tension
- _____ Joint Pain
- _____ Heart Trouble
- _____ Diabetes
- _____ Arthritis
- _____ Headaches/Migraines
- _____ Asthma
- _____ Digestive Disorders
- _____ Nervousness
- _____ Sinus Trouble
- _____ Neck Pain
- _____ High Blood Pressure
- _____ Painful menstrual cycle
- _____ Cancer



Draw the location of your symptoms using these abbreviations:

P for Pain: S for Sharp: N for Numbness