PERSONAL HISTORY

CASE #:_____ DATE: _____ SKYPE user ID: _____

Full Name: _____ E-Mail: _____

Birth Date: _____ Age: _____ Sex: M F Cell Phone: _____

Local Address: _____ **Local** Home Phone: _____

City, State: _____Zip: _____ Work Phone: _____

Out-of-Town Address: _____

Check One: ___ Child ___ Single ___Married ___ Widowed # of Children (if any): _____

Type of Work: _____ Name of Spouse: _____

For in-office visits – name of person here with you today: _____

Emergency Contact Name & Phone: _____

Please indicate who referred you to our office: _____

CURRENT HEALTH CONDITION

Please prioritize your PRIMARY HEALTH CONCERNS: _____

Health Care Professionals seen for this condition:_____

Family members with this condition: _____

PRESCRIPTIONS you regularly take: _____
(Bring them with you – if in office visit)

SUPPLEMENT(S) you regularly take: _____
(Bring with you if an in-office visit)

_____

ALLERGIES: Foods or substances which aggravate your condition or to which you are allergic:

_____

DIET: Please circle diets you follow: Vegan Vegetarian Organic Raw Food Standard American Diet

Caribbean Diet Other: _____

PREVIOUS HEALTH HISTORY

Please indicate any Diagnosis (Diabetes, etc.) organs removed, surgeries/dates, hospitalizations or treatments (radiation, physical therapy, etc.)_____

_____

_____

MAJOR ACCIDENTS OR FALLS & THEIR DATES: _____

Previous Chiropractor's name & last date of visit:_____

PLEASE CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

___Chicken Pox
___ Influenza
___ Measles
___ Mumps
___ Pleurisy
___ Pneumonia
___ Polio
___ Rheumatic Fever
___ Small Pox
___ Thyroid Condition: Type: _____
____ Tuberculosis
____ Whooping Cough
____ Anemia
____ Arthritis
____ Cancer: Where? _____
____ Diabetes
____ Epilepsy
____ Heart Disease
____ Mental Condition

MERCURY TOXINS

# of Mercury Dental Fillings: ____

# of Vaccinations: ____

CHECK IF YOU DRINK:

___ Coffee
___ Tea
___ Alcohol
___Soda
___Cigarettes
___White Sugar
___Dairy

IN THE LAST 6 MONTHS HAVE YOU HAD ANY OF THE FOLOWING BELOW?
PLEASE PLACE A CHECK MARK WHERE APPLICABLE.

MUSCULOSKELETAL
___ Low Back Pain
___ Pain Between Shoulders
___ Neck Pain
___ Arm Pain
___ Joint Pain/Stiffness
___ Walking Problems
___ Difficulty Chewing
___ Pain / Clicking Jaw
___ General Stiffness

GENITO-URINARY
___ Bladder/Urinary
___ Painful/Excessive Urination
___ Discolored Urine

GASTRO-INTESTINAL
___ Poor/Excessive Appetite
___ Excessive Thirst
___ Vomiting
___ Diarrhea
___ constipation
___ Hemorrhoids
___ Liver Problems
___ Gall Bladder Problems
___ Weight Trouble
___ Abdominal Cramp
___ Gas/Bloating After Meals
___ Heartburn
___ Black/ Bloody Stool
___ Colitis

How often do you move your bowels?
_____

NERVOUS SYSTEM
___ Nervous
___ Numbness
___ Paralysis
___ Dizziness
___ Forgetfulness
___Confusion/ Depression
___ Fainting
___ Convulsions
___ Cold/Tingling
___ Extremities
___ Stress

CARDIO-VASCULAR/ RESPIRATORY
___ Chest Pain
___ Shortness of Breath
___ Blood Pressure Prob.
___ Irregular Heart Beat
___ Lung Problems/ Congestion
___ Varicose Veins
___ Ankle Swelling
___ Stroke
___ Heart Attack
___ Heart Valve Issues

Do you have a pacemaker?

Yes ◯ No ◯

FEMALE:
Length of Menses:____ to ____ ◯Days ◯Weeks ◯Months
Time Between Menses: ____to ____ ◯ Days ◯Weeks ◯Months

___ Menstrual Irregularity
___ Menstrual Cramping
___ Clotting during Menses
___ Heavy flow during Menses
___ Vaginal Pain / Infections
___ Hot Flashes
___ Breast Pain / Lumps
___ Sexual Dysfunction

Are you pregnant? ◯Yes ◯ No

When was your last period? _____

MALE:
___Sexual Dysfunction ____ Frequent Urination

GENERAL
___Fatigue
___ Allergies
___ Loss of Sleep
___ Fever
___ Headaches

EAR, EYES, NOSE and THROAT
___ Vision Problems
___ Dental Problems
___ sore Throat
___ Ear Aches
___ Hearing Difficulty
___ Stuffed Nose

Please Check Areas of Discomfort