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Healthy Day Chiropractic

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Patient Name: ____________________

General Health History

Mark the conditions that apply to you.

Past	Present	Condition	Past	Present	Condition
☐	☐	Headaches	☐	☐	Urinary Problems
☐	☐	Migraines	☐	☐	Easy Bruising
☐	☐	Shortness of Breath	☐	☐	Tobacco Use
☐	☐	Allergies / Asthma	☐	☐	Dental Problems
☐	☐	Medication Side Effects	☐	☐	Fibromyalgia
☐	☐	Diabetes	☐	☐	Blood Thinner Use
☐	☐	Hands or Feet Cold	☐	☐	HIV Positive
☐	☐	Muscle Aches	☐	☐	Cancer
☐	☐	Trouble Walking	☐	☐	Depression
☐	☐	Leg / Foot Numbness	☐	☐	Alcohol Use
☐	☐	Fainting	☐	☐	High or Low Blood Pressure
☐	☐	Gall Bladder Trouble	☐	☐	Stroke History
☐	☐	Ringing in Ears	☐	☐	High Cholesterol
☐	☐	Ear Problems	☐	☐	TMJ
☐	☐	Sleeping Problems	☐	☐	Digestive Problems
☐	☐	Vision Problems	☐	☐	Pain All Over
☐	☐	Thyroid Problems	☐	☐	Tension / Irritability
☐	☐	Liver Disease	☐	☐	Chest Pains
☐	☐	Kidney Problems	☐	☐	Heart Pacemaker
☐	☐	Light Bothers Eyes	☐	☐	Heart Problems
☐	☐	Other: ____________________			

1. List any medications you are taking: ____________________

2. Please list all the doctors you are currently seeing: ____________________

3. Has and Doctor or other professional advised you to “Go to a Chiropractor”: ☐ No ☐ Yes, Name ____________________

Past History

4. List any past auto collisions: ____________________ Was any care received? __________
5. List any past work injuries: ____________________ Was any care received? __________
6. List any past sport, recreational,. or home injuries: ____________________
7. Please describe any past conditions and treatment received: ____________________
8. Please list any past hospitalizations and surgeries: ____________________

Family History

Father’s Side: ☐ Heart Disease ☐ Cancer ☐ Diabetes ☐ Heavy Medication Use ☐ Arthritis ☐ Other __________

Mother’s Side: ☐ Heart Disease ☐ Cancer ☐ Diabetes ☐ Heavy Medication Use ☐ Arthritis ☐ Other __________

Is there any other family history you want us to know? ____________________