GONSTEAD CHIROPRACTIC CLINIC

DR.

Patient Health History

Insurance # _____

Name: _____ Age: _____ Date: _____

Address: _____ Home Phone: _____

1. What is your major symptom? _____
_____
2. When was the first time you experienced this problem (specific date)? _____
_____
3. How did it occur? _____
_____
4. Has it become worse recently? _____ If yes, when and how? _____
_____
5. Are there any conditions or symptoms you have that may be related to your major symptom? _____
_____
6. If pain is involved, what type is it...(sharp, dull, achy, throbbing, numbness, tingling, etc.?) _____
_____
7. Is there anything you do which seems to provide relief? _____
_____
8. What things seem to make the problem worse? _____
_____
9. List any other doctors seen for this condition? _____
10. Family MD: _____ Date of Last Physical: _____
11. List conditions you have been treated for in the last five years: _____
_____

List any Allergies: _____

Prior Chiropractic care? _____ By whom? _____ When? _____
Have you had recent X-rays? _____ Please describe: _____
Prior surgery (list with year) _____
Radiation therapy? _____ List medications you are taking: _____
_____

Do you smoke/use tobacco? ____ How much? _____ Alcohol _____ Drugs _____
What hobbies or sports do you enjoy? _____
_____

Sleep Habits_____ Regular Bed_____ Water Bed_____ Number of Pillows_____

Family History: Please list your relatives who have been under care for:

1. Cancer_____
2. Heart Disease_____
3. Back Problems_____
4. Allergies_____
5. High Blood Pressure_____
6. Stroke_____
7. Diabetes _____
8. Nervous Disorders_____

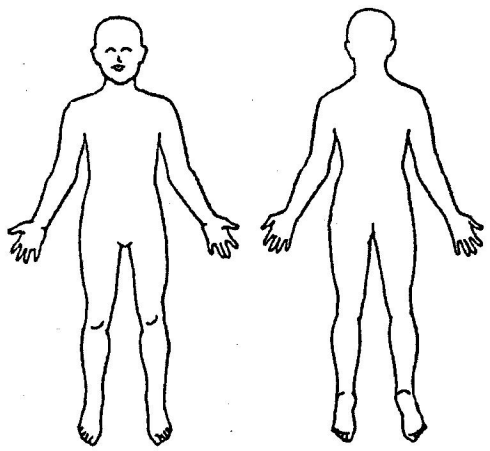
Personal History: Please check if you ***have now*** or *have ever* ***had*** any of the following in the past.

Have	Had	
____	____	Abdominal Pain
____	____	ADD/ADHD
____	____	Allergies
____	____	Ankle Pain
____	____	Anxiety
____	____	Arm Pain
____	____	Arthritis
____	____	Asthma
____	____	Back Pain/Problems
____	____	Bedwetting/Enuresis
____	____	Blood Pressure (High)
____	____	Blood Pressure (Low)
____	____	Cancer (Malignancy history)
____	____	Celiac Disease
____	____	Cerebral Palsy
____	____	Chest Pain
____	____	Constipation
____	____	Convulsions/Seizures
____	____	Cough (Persistent)
____	____	Crohn's Disease
____	____	Dental Problems
____	____	Depression/Other
____	____	Diabetes
____	____	Diarrhea
____	____	Difficulty Breathing
____	____	Difficulty Swallowing
____	____	Difficulty Urinating
____	____	Difficulty Walking
____	____	Dizziness
____	____	Ear Aches/Problems
____	____	Eczema
____	____	Elbow Pain
____	____	Endocrine
____	____	Excessive Gas
____	____	Excessive Thirst
____	____	Excessive Urination
____	____	Excessive Wt. Loss
____	____	Eye/Vision Problems

Have	Had	
____	____	Fainting
____	____	Fatigue
____	____	Fibromyalgia
____	____	Foot Pain
____	____	Forgetfulness
____	____	Fracture(s) (Broken Bones)
____	____	Gallbladder Problems
____	____	Gastric Reflux
____	____	Gout
____	____	Hand Pain
____	____	Headaches
____	____	Headaches (Migraines)
____	____	Hearing problems/loss
____	____	Heart Attack
____	____	Heart Beat-Fast (Tachycardia)
____	____	Heart Beat – Slow (Bradycardia)
____	____	Hemorrhoids
____	____	Hernia (s)
____	____	Hiatal Hernia
____	____	Hip Pain
____	____	Hot Flashes
____	____	Hyperthyroidism
____	____	Hypothyroidism
____	____	Hysterectomy
____	____	Indigestion
____	____	Jaw Pain
____	____	Joint Pain/Stiffness
____	____	Joint Swelling
____	____	Knee Pain
____	____	Leg Pain/Problems
____	____	Loss of Bladder Control
____	____	Low Back Pain
____	____	Menopause
____	____	Menstruation-Heavy
____	____	Menstruation-Irregular
____	____	Menstruation-Painful
____	____	Mid Back Pain

Have	Had	
____	____	Miscarriage (s)
____	____	Multiple Sclerosis
____	____	Muscle Jerking
____	____	Muscles (pain/weakness)
____	____	Nausea/Vomiting
____	____	Neck Pain/problems
____	____	Nervousness
____	____	Neurological Disorder
____	____	Numbness/Tingling
____	____	Osteoporosis
____	____	Pacemaker
____	____	Painful Urination
____	____	Paralysis
____	____	Parkinson's Disease
____	____	Polio
____	____	Poor Sleep
____	____	Prostate Problems
____	____	Psoriasis
____	____	Sciatica
____	____	Scoliosis
____	____	Shoulder pain
____	____	Sinusitis
____	____	Sleep Apnea
____	____	Spinal Cord Injury
____	____	Sprain/Strain
____	____	Stroke
____	____	Stomach Problems
____	____	Swollen Ankles
____	____	Ulcer (s)
____	____	Vaginal Discharge
____	____	Varicose Veins
____	____	Vertigo
____	____	Wrist Pain
____	____	OTHER: _____
____	____	_____
____	____	_____
____	____	_____

Please use the following key to accurately mark the areas in which you feel the described sensations.
Use the appropriate symbols and include all affected areas.



Sharp/Stabbing/Cutting /// /// ///
Tingling (pins and needles) ::::
Burning XXX
Cramping SSS
Dull /achy NNN
Numb ===

Rate current pain from 0 = no pain up to 100 = worst pain ever,
Please write number in box. ☐

Mark on line below indicating present pain level: If you have more than one level of pain, please indicate intensity of each.

No pain [—|—|—|—|—|—|—|—|—|—] Worst pain
0 100