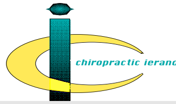


HEALTH HISTORY – *CONFIDENTIAL* Date:____________

Name:____

Main complaint and symptoms:____

____

____

How long have you had this problem? ___day(s) ____week(s) ____month(s) ___ year(s)

This problem is getting… better☐ worse☐ stays the same☐ comes & goes☐ .

Other treatment sought for this, and results:____________________________________

____

List any diagnosis of prior doctors:____

Have you missed / lost any work due to this condition?___________________________

What makes your condition worse?____

What makes your condition better?____

I also suffer from:____

____

Is this a workers compensation or third party claim? YES☐ NO☐ .

Have you ever had any accidents or falls?

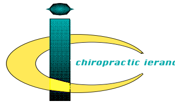
Date	Describe the accident Eg: fell on pavement on left hand	Injuries Eg: broke wrist	Treatment Eg: cast, hospital
1			
2			
3			

Have you had any x rays? NO☐ If yes, complete below: date:

Body part:	

Ever had any blood tests? Please list dates and results:___________________________

Ever had any urine tests? Please list dates and results:



Have you ever had surgery? Give details below:

Type	Year	Did it help you?

List any major illnesses you have ever had:____

____

Are you allergic to anything? No☐ If yes, list:____________________________________
List type and date of any fractures or dislocations:__________________________________

____

Are you taking any of the following:
☐Medication____
☐Nutritional supplements____
☐Recreational drugs ☐birth control pills ☐pain killers ☐aspirin other____________

BIRTH AND CHILDHOOD

Were you:
☐A forceps delivery ☐a long labour ☐difficult birth ☐caesarean ☐immunised
Have you had:
☐Chicken pox ☐mumps ☐measles ☐whooping cough other_______

FAMILY HISTORY

	GOOD	POOR	Had the following significant health conditions:
MOTHER'S HEALTH			
FATHER'S HEALTH			
OTHER			

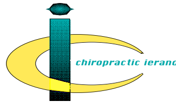
Please indicate if any of the following is currently or has contributed to some stress or personal lifestyle changes the past five years:

☐ Marriage
☐ Birth of child
☐ Divorce
☐ Marital problems
☐ Death in family, or friend
☐ Disabled household member
☐ Care giver to relative
☐ Change in financial status
☐ Spousal abuse
☐ Change or loss of job
☐ Retirement
☐ Other_________________

HABITS

Alcohol	Drinks per week________ any family history of alcoholism?________
Tea	Cups per day__________ types:
Coffee	Cups per day__________ decaf? ☐ .
Sleep	Ave. hours per day______ I sleep on my stomach☐ side☐ back Age of mattress is _______ years I have poor irregular sleep patterns☐ .
Smoking	Cigs per day______ Quit ___yrs ago Previously smoked for ____yrs
Exercise	Usually ___mins / hours per day / week ☐Do not do as much as I need

PLEASE fill in the BACK of this PAGE…



Have you been to a chiropractor before? ☐No. Date of last visit, if yes______________
Name of the chiropractor(s)____
Did they help you?____

FEMALES ONLY
Date of last menstrual period
Do you have any reason to believe you are pregnant? ☐Yes ☐No ☐maybe

SOCIAL HISTORY

List any activities you engage in socially, and any SPORTS:

____

____

List any activities that you can no longer engage in because of your health

____

WORK

Does your work involve a lot of:

☐	Sitting	☐	Arms above head ….how long?____________
☐	Standing	☐	Driving….how long? _______________
☐	Bending	☐	Dealing with people
☐	Lifting, up to how many kg? ___	☐	Other:

Are you satisfied with your job?____________________________Is it noisy? ________
Do you feel stress on the job? Describe____

VISUAL PAIN SCALE:
Rate the pain:

(list each complaint on the line, then rate it from zero to ten)

__________________ none 0-----|-----|-----|-----|-----|-----|-----|-----|-----|-----10 worst ever

__________________ none 0-----|-----|-----|-----|-----|-----|-----|-----|-----|-----10 worst ever

__________________ none 0-----|-----|-----|-----|-----|-----|-----|-----|-----|-----10 worst ever

__________________ none 0-----|-----|-----|-----|-----|-----|-----|-----|-----|-----10 worst ever

PLEASE SIGN BELOW, AND THEN <u>TURN OVER</u> FOR THE LAST SECTION

Date: Signature:

PLEASE fill in the BACK of this PAGE…