Confidential Patient History

Dear Patient: Please complete this form and questionnaire. If you need assistance, please ask. Your answers will help us determine if chiropractic care can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. THANK YOU.

In general, would you say your health is (check one): ☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

PAST HEALTH HISTORY:

1. Have you ever experienced your present problem before for which you are consulting us: ☐ Yes ☐ No If yes, When: ______________
   Was treatment provided: ☐ Yes ☐ No If yes, By whom: ______________________________ Outcome: __________________
   ____

2. Have you **ever** had a **stroke** or issues with **blood clotting**?: ☐ Yes ☐ No If yes, when: ____________________________________

3. Have you recently experienced **dizziness**, unexplained **fatigue**, **weight loss**, or **blood loss**?: ☐ Yes ☐ No If yes, explain:_________________
____

4. Have you **ever** had any **major illnesses, injuries, broken bones, hospitalizations, accidents, or surgeries?** ☐ Yes ☐ No

Date	Injury/ Fracture/ Illness/ Surgeries	Treatment	Results

SYSTEMS REVIEW QUESTIONS:
Do you or have you ever had any problems with the following areas? (Please mark **Y** for yes or **N** for no in each of the following):

1. _____ Eyes
2. _____ Ears, Nose, Mouth, Throat
3. _____ Heart
4. _____ Lungs/ Breathing
5. _____ Intestines/Bowels
6. _____ Urinary
7. _____ Muscles
8. _____ Nerves
9. _____ Joints/Bones
10. _____ Skin
11. _____ Internal Organs
12. _____ Blood
13. _____ Allergies
14. _____ Psychological/Emotional

Females only:

15. _____ Gynecological/Menstrual/Breast

Males Only:

16. _____ Prostate/Testicular/Penile

Please explain any above **Yes** answers:
____
____
____

SOCIAL HISTORY:
Recreational Activities (Hobbies): ____

Yes	No	
□	□	Do you exercise?: ________________ times per week.
□	□	Do you smoke?: ________________ packs per day.
		If you have quit smoking, when did you quit?: ___________________________________
□	□	Do you use other forms of tobacco? What/How much per day?: ___________________________________
□	□	Do you consume alcohol? How many drinks per week?: ___________________________________
□	□	Do you eat a balanced low fat diet? If no, explain: ___________________________________
□	□	Do you get adequate sleep? If no, explain: ___________________________________
□	□	Is work stressful to you? If yes, explain: ___________________________________
□	□	Is family life stressful to you? If yes, explain: ___________________________________
□	□	Do you use recreational drugs? If yes, explain: ___________________________________

Name:____ Date:____________________________