



# Conscious Chiropractic & Acupuncture

## Health History

Welcome to Conscious Chiropractic & Acupuncture. Please fill out this questionnaire.

Date: \_\_\_\_\_

Patient name \_\_\_\_\_ Birthdate \_\_\_\_\_ Patient # \_\_\_\_\_

Why are you seeing the doctor? \_\_\_\_\_

This is a  New  Old illness? If treated before, what was done? \_\_\_\_\_

By whom? \_\_\_\_\_ When? \_\_\_\_\_

Describe your dietary/nutritional habits \_\_\_\_\_

Do you exercise regularly?  Yes  No Type of exercise & duration: \_\_\_\_\_

Doctor Notes: \_\_\_\_\_

Previous Hospitalization/Surgeries/Serious Illnesses	When	Hospital, City, State
_____	_____	_____
_____	_____	_____

Medications: (Include non-prescription) \_\_\_\_\_

Auto accidents: \_\_\_\_\_

### Patient social history

Marital status:  Single  Married/Significant other

Alcohol use:  Never  Occasionally  Daily

Tobacco use:  Never  Previously, but quit  Current packs/day \_\_\_\_\_

Recreational drug use:  Never  Previously, but quit  Type/Frequency \_\_\_\_\_

Excessive exposure at home or work to:  Fumes  Dust  Solvents  Airborne Particles  Noise

Person to contact in case of emergency \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

### Family Health Information

Information about your immediate family members (brothers, sisters parents, grandparents) will give us a better understanding of your total health picture.

Relationship	Significant present and past health problems
_____	_____
_____	_____
_____	_____

Are you wearing:  Heel lifts  Sole lifts  Inner Soles  Arch supports

How old is your mattress? \_\_\_\_\_ Is it comfortable?  Yes  No

How old is your pillow? \_\_\_\_\_ Type of pillow \_\_\_\_\_ Is it comfortable?  Yes  No

For women: If using birth control methods, what type? \_\_\_\_\_

Are you pregnant?  Yes  No LMP \_\_\_\_\_ Nursing?  Yes  No

## Past Medical History

Have you ever had the following: (circle "no" or "yes", leave blank if uncertain)

Measles	no	yes	Tuberculosis	no	yes	Glaucoma	no	yes
Anemia	no	yes	Ulcer	no	yes	Infectious Mono	no	yes
Hepatitis	no	yes	Diphtheria	no	yes	Heart disease	no	yes
Mumps	no	yes	Diabetes	no	yes	Hernia	no	yes
Bladder infection	no	yes	Asthma	no	yes	Bronchitis	no	yes
High blood pressure	no	yes	Cancer	no	yes	Arthritis	no	yes
Chickenpox	no	yes	Hives or Eczema	no	yes	Thyroid Disease	no	yes
Epilepsy	no	yes	Pneumonia	no	yes	Mitral Valve Prolapse	no	yes
Low blood pressure	no	yes	Polio	no	yes	Kidney Disease	no	yes
Migraine Headache	no	yes	AIDS or HIV+	no	yes	Stroke	no	yes
Hemorrhoids	no	yes	STD	no	yes			
Scarlet Fever	no	yes	Rheumatic Fever	no	yes			

Please list any other conditions \_\_\_\_\_

## Review of Systems: Please indicate any personal history below:

### Constitutional Symptoms

Good general health lately	no	yes
Recent weight change	no	yes
Fever	no	yes
Fatigue	no	yes
Headaches	no	yes

### Eyes

Eye disease or injury	no	yes
Wear glasses / contact lenses	no	yes
Blurred or double vision	no	yes

### Ears/Nose/Mouth/Throat

Hearing loss or ringing	no	yes
Earaches or drainage	no	yes
Chronic sinus problem or rhinitis	no	yes
Nose bleeds	no	yes
Mouth Sores	no	yes
Bleeding gums	no	yes
Bad breath or bad taste	no	yes
Sore throat or voice change	no	yes
Swollen glands in neck	no	yes

### Cardiovascular

Heart trouble	no	yes
Chest pain or angina	no	yes
Palpitations	no	yes
Shortness of breath	no	yes
Swelling (feet, ankles or hands)	no	yes

### Musculoskeletal

Joint pain	no	yes
Joint stiffness or swelling	no	yes
Weakness of muscle or joints	no	yes
Muscle pain or cramps	no	yes
Back pain	no	yes
Neck pain	no	yes
Cold extremities	no	yes
Difficulty walking	no	yes

### Genitourinary

Frequent urination	no	yes
Burning / painful urination	no	yes
Blood in urine	no	yes
Incontinence or dribbling	no	yes
Kidney stones	no	yes
Sexual difficulty	no	yes
Male – testicle pain	no	yes
Female – painful periods	no	yes
irregular periods	no	yes
vaginal discharge	no	yes
# of pregnancies	_____	
# of miscarriages	_____	
date of last pap smear	_____	

### Integumentary

Rash or itching	no	yes
Change in skin color	no	yes
Change in hair or nails	no	yes
Varicose veins	no	yes
Breast pain or lump	no	yes
Breast lump	no	yes
Nipple discharge	no	yes

### Neurological

Frequent headaches	no	yes
Light headed or dizzy	no	yes
Convulsions or seizures	no	yes
Numbness or tingling	no	yes
Tremors	no	yes
Paralysis	no	yes
Head injury	no	yes

### Psychiatric

Memory loss or confusion	no	yes
Nervousness	no	yes
Depression	no	yes
Insomnia	no	yes

### Gastrointestinal

Loss of appetite	no	yes
Change in bowel movements	no	yes
Nausea or vomiting	no	yes
Frequent diarrhea	no	yes
Painful bowel movements		
or constipation	no	yes

### Endocrine

Glandular or hormone problem	no	yes
Excessive thirst or urination	no	yes
Heat or cold intolerance	no	yes
Skin becoming dryer	no	yes
Change in hat or glove size	no	yes

### Hematologic/Lymphatic

Slow to heal after cuts	no	yes
Bruising easily	no	yes
Anemia	no	yes
Phlebitis	no	yes
Past transfusion	no	yes
Enlarged glands	no	yes

### Respiratory

Chronic or frequent coughs	no	yes
Spitting up blood	no	yes
Wheezing	no	yes

### Allergic/Lymphatic

History of skin reaction or other adverse reaction to:		
Penicillin or other antibiotics	no	yes
Novocaine or other anesthetics	no	yes
Aspirin or other pain remedies	no	yes
Iodine, Merthiolate or other antiseptic	no	yes

Other allergies: \_\_\_\_\_

Signature of Patient, Parent or Guardian

Date

Doctor Review

Signature of Doctor

Date