Health History

Name: **Chart #:** **Today's Date:** **Date of Onset:**

Please select all choices that apply to the patient.

☐ Abdominal Pain	☐ Colitis	☐ Headaches	☐ Irritable Colon	☐ Osteoporosis	☐ Sinus Trouble
☐ Allergies	☐ colon cancer	☐ Heart Attacks	☐ Kidney Disease	☐ Painful Urination	☐ Spinal Disc Disorder
☐ Angina	☐ Convulsions	☐ Heart Disease	☐ Kidney Stones	☐ peptic ulcer	☐ STDs
☐ Anorexia	☐ Diabetes	☐ hepatitis A	☐ kyphosis	☐ PMS	☐ stomach cancer
☐ Aortic Aneurysm	☐ juvinile diabetes	☐ hepatitis B	☐ leg pain	☐ Polio	☐ stomach ulcer
☐ Arthritis	☐ adult diabetes	☐ hepatitis C	☐ Liver Disease	☐ Profuse Menstrual	☐ Stroke
☐ Asthma	☐ Dislocated Joints	☐ High Blood Pressure	☐ lordosis	☐ prostate cancer	☐ Thyroid Disorder
☐ Blood Disorder	☐ Dizziness	☐ hip pain	☐ Low Blood Pressure	☐ Prostate Problems	☐ traumatic arthritis
☐ Bone Cancer	☐ duodenum ulcer	☐ HIV/AIDS	☐ lower back pain	☐ Rapid Heart Rate	☐ Tuberculosis
☐ brain cancer	☐ Emphysema	☐ hypertension	☐ lung cancer	☐ rectum cancer	☐ Ulcer
☐ Breast Soreness	☐ Epilepsy	☐ hyperthyroidism	☐ Lung Disease	☐ rheumatoid arthritis	☐ upper back pain
☐ breast cancer	☐ esophageal cancer	☐ hypotension	☐ migrane	☐ Rheumatic Fever	☐ Vaginal Discharge
☐ Bulemia	☐ Fainting	☐ hypothyroidism	☐ Multiple Sclerosis	☐ Scoliosis	☐ _____
☐ Cancer	☐ gouty arthritis	☐ Irregular Bowel Habits	☐ neck pain	☐ shoulder pain	☐ _____
☐ chest pain	☐ Hay Fever	☐ Irregular Menstrual	☐ osteo arthritis	☐ Sickle Cell Anemia	☐

Select all choices that apply to the patient's family (please do not include relations by marriage).

☐ Abdominal Pain	☐ Colitis	☐ Headaches	☐ Irritable Colon	☐ Osteoporosis	☐ Sinus Trouble
☐ Allergies	☐ colon cancer	☐ Heart Attacks	☐ Kidney Disease	☐ Painful Urination	☐ Spinal Disc Disorder
☐ Angina	☐ Convulsions	☐ Heart Disease	☐ Kidney Stones	☐ peptic ulcer	☐ STDs
☐ Anorexia	☐ Diabetes	☐ hepatitis A	☐ kyphosis	☐ PMS	☐ stomach cancer
☐ Aortic Aneurysm	☐ juvinile diabetes	☐ hepatitis B	☐ leg pain	☐ Polio	☐ stomach ulcer
☐ Arthritis	☐ adult diabetes	☐ hepatitis C	☐ Liver Disease	☐ Profuse Menstrual	☐ Stroke
☐ Asthma	☐ Dislocated Joints	☐ High Blood Pressure	☐ lordosis	☐ prostate cancer	☐ Thyroid Disorder
☐ Blood Disorder	☐ Dizziness	☐ hip pain	☐ Low Blood Pressure	☐ Prostate Problems	☐ traumatic arthritis
☐ Bone Cancer	☐ duodenum ulcer	☐ HIV/AIDS	☐ lower back pain	☐ Rapid Heart Rate	☐ Tuberculosis
☐ brain cancer	☐ Emphysema	☐ hypertension	☐ lung cancer	☐ rectum cancer	☐ Ulcer
☐ Breast Soreness	☐ Epilepsy	☐ hyperthyroidism	☐ Lung Disease	☐ rheumatoid arthritis	☐ upper back pain
☐ breast cancer	☐ esophageal cancer	☐ hypotension	☐ migrane	☐ Rheumatic Fever	☐ Vaginal Discharge
☐ Bulemia	☐ Fainting	☐ hypothyroidism	☐ Multiple Sclerosis	☐ Scoliosis	☐ _____
☐ Cancer	☐ gouty arthritis	☐ Irregular Bowel Habits	☐ neck pain	☐ shoulder pain	☐ _____
☐ chest pain	☐ Hay Fever	☐ Irregular Menstrual	☐ osteo arthritis	☐ Sickle Cell Anemia	☐

Patient exercises:	☐ Moderately	☐ Occasionally	☐ Rarely	☐ Regularly	☐ Never
Patient smokes:	☐ 2 packs per day	☐ ½+ pack per day	☐ Never	☐ _____	☐ _____
☐ 2+ packs per day	☐ 1 pack per day	☐ ½ pack a day or less	☐	☐	☐
Patient uses alcohol:	☐ Excessively	☐ Moderately	☐ Occasionally	☐ Rarely	☐ Never
Medication the patient is currently taking:		☐ Muscle Relaxants	☐ No prescription	☐ Psychotropic	☐ _____
☐ Analgesics	☐ Birth Control	☐ No non-prescription	medications	medication	☐ _____
☐ Anti-Inflamatory	☐ Hypertension	medication	☐ Tranquilizers	☐ Vitamin supplements	☐
Allergies - please mark all that apply:		☐ Dust	☐ Penicillan	☐ Pollen	☐ Sulfa Drugs
☐ Animal Dander	☐ Dairy Products	☐ Latex	☐ Perfumes	☐ Secondary Smoke	☐ No known allergies

Who is/was your most recent general physician? _____

What was his/her diagnosis? _____

Who was your last Doctor? _____

What were his/her findings? _____

Please list any previous injuries and/or accidents with approximate dates:

Past Surgical History (inlcude date, location, surgeon's name, the type of surgery, and list complications)

_____ _____

_____ _____

Past Hospitalizations (date, complications, and cause of hospitalization)

_____ _____

_____ _____

History of Pregnancy _____

Treatment and Diagnostic

☐	***Plain X-Rays***	*Date* _____	*Location* _____	*Results* _____			
☐	***CT Scan***	*Date* _____	*Location* _____	*Results* _____			
☐	***MRI***	*Date* _____	*Location* _____	*Results* _____			
☐	***EMG***	*Date* _____	*Location* _____	*Results* _____			
☐	***Thermogram***	*Date* _____	*Location* _____	*Results* _____			
☐	***Bone Scan***	*Date* _____	*Location* _____	*Results* _____			
☐	***Discogram***	*Date* _____	*Location* _____	*Results* _____			
☐	***Myelogram***	*Date* _____	*Location* _____	*Results* _____			
☐	***Nerve Block Injection***	☐	***Facett Injection***	☐	***Bioelectric Treatment***	☐	***Other*** _____
☐	***Trigger Point Injection***	☐	***Tendon Shealth Injection***	☐	***EMG Needle Exam***	☐	***Other*** _____
☐	***Joint Injection***	☐	***Botox Injection***	☐	***Spinal Infusion Pump***	☐	***Other*** _____
☐	***Epidural Injection***	☐	***IV***	☐	***Spinal Cord Stimulator***		

I understand that the information I have provided above is current and complete to the best of my knowledge. **Initial:**