DENN CHIROPRACTIC
Healing the Body From Within

HEALTH HISTORY FORM

NAME:_____ **DATE**:_____/_____/_____

Reason for seeking Chiropractic care?_____

When did it start?_____

Have you ever seen a Chiropractor before? Yes / No **Reason for previous chiropractic care**?_____

Reason for chiropractic care today? Pain relief / pain relief, improved spinal posture / Overall spinal wellness

Past Medical History: (Please check all that apply) ***DC comments***:_____

___headaches	___dizziness	___allergies	___sinus problems	___asthma
___TMJ problems	___jaw pain	___depression	___vertigo	___arthritis
___fractures	___cancer	___diabetes	___previous strokes	___seizures
___heart problems	___pacemaker	___high blood pressure	___high cholesterol	___prostate
___bowel & bladder	___chest pain	___vision problems	___menstrual problems	___fatigue issues
___car accidents	___sports injury	___work injuries	___diarrhea/constipation	___Hearing issues

Family History: [Mother, Father, Brother, Sister,] (Please check any box that applies)

	Heart Dx	Diabetes	Cancer	Osteoarthritis	Alzheimer's	High BP	High Chol.	Dementia	Parkinson's Dx
Dad/Mom									
Brother									
Sister									

Social History:	**Daily**	**Weekly**	**Other**		**Daily**	**Weekly**	**Other**	***DC comments:***
Alcohol use	_____	_____	_____	Exercising	_____	_____	_____	_____
Tobacco use	_____	_____	_____	Medications	_____	_____	_____	_____
Caffeine use	_____	_____	_____	Stress	_____	_____	_____	

Activities of Daily Living: *(How does your current condition affect your everyday activities and ability to function)*

	No Effect	**Mildly**	**Moderately**	**Severely**		**No Effect**	**Mildly**	**Moderately**	**Severely**
Sitting	_____	____	_____	_____	Exercising	_____	_____	_____	_____
Standing	_____	____	_____	_____	Showering	_____	_____	_____	_____
Walking	_____	____	_____	_____	House Cleaning	_____	_____	_____	_____
Lifting	_____	____	_____	_____	Sleeping	_____	_____	_____	_____
Bending	_____	____	_____	_____	Bending Over	_____	_____	_____	_____
Driving	_____	____	_____	_____	Getting Dressed	_____	_____	_____	_____

Please check any Medications and Supplements you are taking now *(Check all that apply)*

___Anxiety meds. ___Muscle Relaxants ___Pain Killers ___Insulin ___Allergies ___Birth control

___Blood Pressure ___Cholesterol ___Heart Problems ___Seizures ___ADHD ___Stomach Meds

___Vitamin B's ___Vitamin D's ___Calcium ___Fish oils ___Magnesium ___Tumeric

___Other:_____

Please describe the type of pain you are having:

___dull ___sharp ___stabbing

___numbness ___burning ___tingling

___achy ___shooting ___radiating

How often are your current symptoms:

___constantly (76-100%) ___frequently (51-74%)

___occasionally (26-50%) ___Intermittent (25% or less)

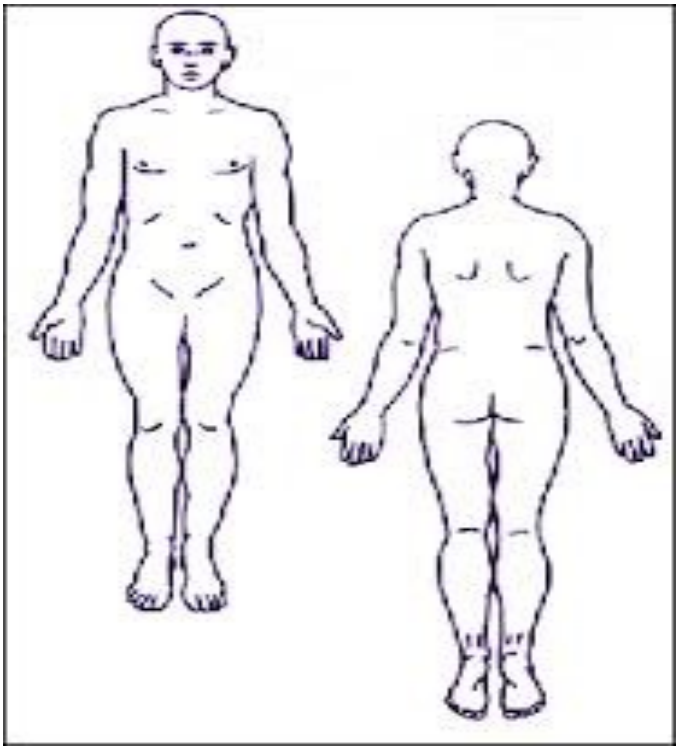
___coming/going (with certain actions or movements)

Are your symptoms changing?

___better ___same ____getting worse

If Yes how long? _____

Please circle areas of complaints



Was this injury work related? Yes / No

(If yes, please let the front desk know)

Have you ever had these or similar symptoms before?

Yes / No

(*If yes, please list when)* _____

Please grade your pain/symptoms:

(0=no pain) (10= severe pain)

0 1 2 3 4 5 6 7 8 9 10

Please circle the things that aggravate your condition:

Bending / Lifting / Twisting / Pushing / Pulling / Driving / Sitting / Standing / Sleeping

Walking / Working / Exercises / Cleaning / Sports / Overhead work / Computer work / Carrying child

Other _____

Please circle things that relieve your condition:

Ice packs / Heating pad / Resting / Lying down / Medications / Bio-freeze

Standing / Sitting / Exercises / Stretching / Chiropractic / Massage

Other _____

Please note that all patients are required to have an examination for determining if chiropractic care is warranted for your condition. With my signature, I agree to allow Denn Chiropractic LLC to use all chiropractic means to determine my care.

NAME:_____ **DATE:**_____/_____/_____