Denn Chiropractic Clinic LLC

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HEALTH HISTORY FORM

NAME:_____
DATE:_____/_____/_____
Reason for seeking Chiropractic care?
_____ When did it start?
_____
Have you ever seen a Chiropractor before? Yes / No If yes, when?
_____
Reason for previous chiropractic care?
_____

Past Medical History: (Please check all that apply)

___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

Family History: [Mother, Father, Brother, Sister, Parents on both sides] (Please check all that apply)

___ Arthritis ___ Cancer ___ Scoliosis ___ Rheumatoid Arthritis ___ Diabetes
___ Heart Disease ___ Auto Immune diseases
___ Other_____

Social History:

	Daily	Weekly	How often		Daily	Weekly	How often
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	_____	_____	_____	_____

Are you taking any current medications for your current problem or any other problems?
(Please check all that apply)
___Anxiety meds. ___Muscle Relaxants ___Pain Killers ___Insulin ___Allergies
___Birth control ___Blood Pressure ___Cholesterol ___Seizures ___Heart problems
___ADHD/Hyperactive ___Stomach meds.
___Other (s)_____

Please describe the type of pain you are having:
___dull ___sharp
___stabbing
___numbness ___burning
___tingling
___achy ___shooting ___radiating

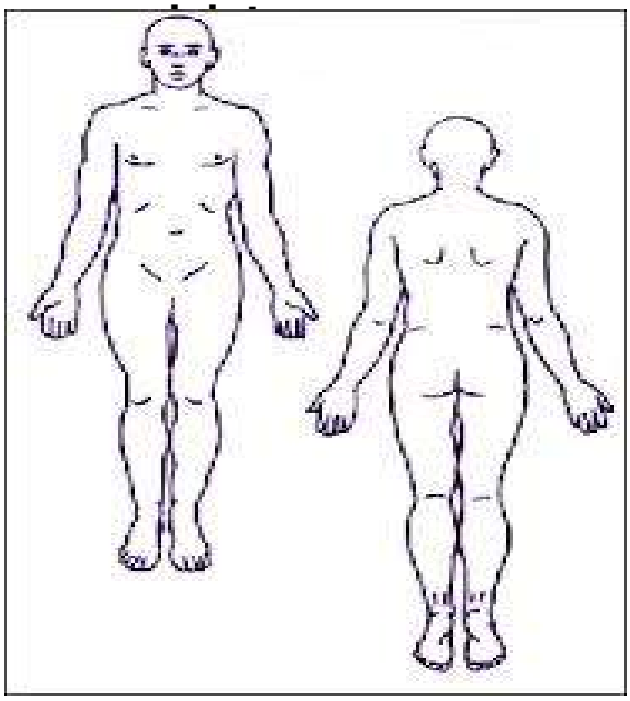
How often are your current symptoms:
___constantly ___frequently
___occasionally ___periodically
___intermittent ___coming/going

Are your symptoms changing?
___better ___same ____getting worse

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 circle areas of



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:_____/_____/_____