Patient Health History

Please circle all that apply to your health history

Head

- Headache
- Migraine
- Light-headedness
- Dizziness
- Pain in ears
- Other_____

Neck

- Pain with movement
- Pinched nerve
- Muscle Spasm
- Other_____

Shoulders

- Pain in joint (L or R)
- Can't raise arm (L or R)
- Pinched Nerve
- Muscle Spasm
- Other_____

Arms and Hands

- Pain in upper arm, forearm, elbow, Hands, Fingers
- Sensation of pins/needles Location: _____
- Numbness / Tingling Location: _____
- Swollen Joints Location: _____
- Loss of grip strength
- Cold hands
- Other: _____

Mid-Back

- Pain
- Pain between Shoulder blades
- Sharp stabbing pain
- Dull ache
- Pain from front to back
- Muscle spasm
- Pain in kidney area
- Other: _____

Chest

- Chest pain
- Shortness of breath
- Pain around ribs
- Breast pain
- Irregular heartbeat
- Other: _____

Abdomen

- Nervous stomach
- Nausea
- Gas
- Constipation
- Diarrhea
- Hemorrhoids
- Other: _____

Low back

- Low back pain
- Sacroiliac Pain
- Stabbing pain
- Shooting pain
- Dull ache
- Slipped disk
- Muscle spasm
- Pain worsens with:
  - Working
  - Lifting
  - Standing
  - Sitting
  - Bending
  - Coughing
  - Lying down
  - Walking
  - Other: _____

Hips Legs and Feet

- Pain in buttocks
- Pain in hip joint (L or R)
- Pain down leg (L or R)
- Knee pain (L or R)
- Leg Cramps (L or R)
- Pins and needles sensation (L or R)
- Numbness of leg (L or R)
- Numbness of Foot (L or R)
- Numbness in toes (L or R)
- Feet feel cold
- Swollen ankles (L or R)
- Swollen feet (L or R)
- Other: _____

MEN ONLY

- Urinary Frequency
- Difficulty in starting
- Night urination
- Prostate pain/swelling
- Other: _____

Patient Name:

Date:

What is the main reason for your visit?

_____

_____

_____

WOMEN ONLY

- Menstrual pain
- Cramping
- Irregularity
- Birth Control
- Hysterectomy
- Cancer
- Abortions _____
- Do you think you might be pregnant (Y or N)
- Due date: _____

General

- Nervousness
- Irritable
- Depressed
- Fatigue
- Loss of Sleep
- Weight gain/Loss

MEDICAL HISTORY

(If any of the following are relevant to your current or past health history please circle the accompanying bullet)

- Diabetes
- Hypoglycemia
- Muscular dystrophy
- Rheumatic Fever
- Digestive Disorders
- Multiple Sclerosis
- Convulsions
- Measles
- Heart trouble _____
- High Blood pressure
- Venereal Disease
- Cancer _____
- Polio
- Scarlett Fever
- Tuberculosis
- Concussion
- Arthritis _____
- Hepatitis
- Other: _____
- Surgeries

  _____

  _____