# Health History

1. What is your MAJOR COMPLAINT today? _____
2. WHEN did this episode begin? _____
3. HOW did this episode begin?_____
4. Is the pain getting better, worse, or staying the same? _____
5. Is the pain stopping you from doing any of your normal daily activities? YES NO If yes, please describe:
   _____
6. Are you pregnant or trying to get pregnant? YES NO How far along? _____
7. Have you had this pain/discomfort before? If yes, what treatment did you get? :
   _____
8. Is the pain CONSTANT FREQUENT or does it COME AND GO?
9. Does the pain radiate? YES NO If yes, where? Arm R/L Hand R/L Buttock R/L Leg R/L Foot R/L
10. WHEN is the pain worse: Morning Afternoon Evening Sleeping As day progresses No change
11. WHAT makes the pain worse? Walking Standing Sitting Bending Lifting Trying to stand up Driving Work Sports Sleeping Coughing Sneezing Laughing Other:_____
12. WHEN is the pain better: Morning Afternoon Evening Sleeping As day progresses No change
13. WHAT makes the pain BETTER? Ice Heat Stretches Sitting Lying Down Standing Walking Medication Chiropractic Other:_____
14. Do you have any weakness in your arms legs hands? YES NO
15. Do you have any recent changes in your bowel or bladder? YES NO
16. Are you RIGHT or LEFT handed?
17. Height: ___ft ___in Weight: _____lbs
18. List any major SURGERIES, major ILLNESSES, TRAUMAS, or FRACTURES
    BODY PART:_____ DATE: _____ BODY PART:_____ DATE:_____
    BODY PART: _____ DATE: _____ BODY PART:_____ DATE:_____
19. Please indicate illness on family history; Cancer, Diabetes, Stroke, Heart Condition, other:
    Mother: _____ Father: _____
    Sister: _____ Brother: _____
    Maternal Grandmother: _____ Maternal Grandfather: _____
    Paternal Grandmother: _____ Paternal Grandfather: _____
20. Marital Status: SINGLE MARRIED DIVORCED WIDOWED
21. Alcohol use: NONE CASUAL MODERATE HEAVY Type: BEER LIQUOR WINE
22. Caffeine use: NONE <3 CUPS/DAY 4-6 CUPS/DAY 6+ CUPS/DAY
23. Tobacco use: NONE FORMER SOCIALLY DAILY
24. Type of tobacco: SMOKE SMOKELESS VAPE
25. Exercise: NONE DAILY WEEKLY WALKS RUNS SWIMS WEIGHTS
26. Do you have any OTHER SYMPTOMS you would like to discuss at this time?
    _____

Patient Name: _____

Patient Signature: _____

Date: _____