

# Health History Form

**GENERAL SYMPTOMS**

Never Presently

- Bronchitis
- Chills
- Convulsions
- Dizziness
- Fainting
- Fatigue
- Fever
- Headache
- Loss of sleep
- Loss of weight
- Nervousness
- Neuralgia
- Night sweats
- Numbness/pain in arms/legs/hands
- Wheezing
- Allergy to what: \_\_\_\_\_

**GASTRO-INTESTINAL**

Never Presently

- Belching or gas
- Colon trouble
- Constipation
- Diarrhea
- Excessive hunger
- Gall bladder trouble
- Hemorrhoids (Piles)
- Jaundice
- Liver trouble
- Nausea
- Pain over stomach
- Poor appetite
- Poor digestion
- Vomiting
- Vomiting blood

**EAR/NOSE/THROAT**

Never Presently

- Asthma
- Crossed Eyes
- Deafness
- Earache
- Ear discharge
- Ear noise
- Enlarged thyroid
- Frequent colds
- Hayfever
- Hoarseness
- Nasal obstruction
- Nose bleeds
- Pain in eyes
- Poor vision
- Sinusitis
- Sore throats
- Tonsillitis

**RESPIRATORY**

Never Presently

- Chest pain
- Chronic cough
- Difficulty breathing
- Spitting blood
- Spitting phlegm

**GENITO-URINARY**

- Bed wetting
- Blood in urine
- Frequent urination
- Inability to control urine
- Kidney infection
- Painful urination
- Prostrate trouble

**MUSCLES & JOINTS**

- Backache
- Foot trouble
- Hernia
- Pain between shoulders
- Painful tailbone
- Stiff neck
- Spinal curvature
- Swollen joints
- Tremors
- Twitching
- Weakness

**CARDIO-VASCULAR**

- High blood pressure
- Low blood pressure
- Pain over heart
- Poor circulation
- Heart trouble
- Rapid heart
- Slow heart
- Stroke
- Swollen ankles
- Varicose veins

**SKIN OR ALLERGIES**

- Boils
- Bruise easily
- Dryness
- Eczema
- Hives or allergy
- Itching
- Sensitive skin
- Skin eruptions

**FOR WOMEN ONLY**

- Cramps or backaches
- Excessive flow
- Hot flashes
- Irregular cycle
- Miscarriage
- Painful periods
- Vaginal discharge
- Y  N  Pregnant at this time?

Date of last papsmear: \_\_\_\_\_

List any accidents or falls and dates:  Car \_\_\_\_\_  Recreation Vehicle \_\_\_\_\_  
 Sports \_\_\_\_\_  School \_\_\_\_\_  Other \_\_\_\_\_

List any broken bones (fractures) or dislocations: \_\_\_\_\_

Ever on crutches?  No  Yes Why? \_\_\_\_\_

Have you ever had any spinal taps or spinal injections?  No  Yes Were you ever knocked unconscious?  No  Yes

Have you ever had a lapse of memory?  No  Yes Have you ever had X-rays taken?  No  Yes When? \_\_\_\_\_

For what ailments were these X-rays taken? \_\_\_\_\_

Do you suffer from any condition other than that for which you are now consulting us? \_\_\_\_\_

Are you currently taking any medication ñ prescription or over-the-counter?  No  Yes What? \_\_\_\_\_

I have completed this 3-page form to the best of my ability.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_