41 NORTH
CHIROPRACTIC &
SOFT TISSUE CLINIC P.C.

NAME: _____
DATE: ____/____/____

HEALTH HISTORY

What treatment have you already received for your condition? Please circle below:

Ice Heat Massage Chiropractic Physical Therapy Medication Surgery

Name of other doctor(s) who have treated you for your condition _____

Do you have any other health conditions our staff should be made aware of? _____

_____

_____

_____

Have you…..	Yes	No	If yes, explain briefly:
…been hospitalized in the last 5 years?			_____
…had any mental disorders?			_____
…had any broken bones?			_____
…had any strains or sprains?			_____
…ever used orthotics?			_____
…had any falls?			_____
…had any head injuries?			_____
…motor vehicle accident?			_____

What surgeries have you had? _____

_____

_____

_____

Date of last:

Physical Exam _____ Spinal X-Ray _____ Blood Test _____

Spinal Exam _____ Chest X-Ray _____ Urine Test _____

Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Mammogram _____ Was it normal or abnormal? _____

PAP Test _____ Was it normal or abnormal? _____

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Are you pregnant? _____ If yes, when is your due date? _____

Pharmacy Name _____

Pharmacy Phone (____)_____

EXERCISE

None

Moderate

Daily

Heavy

WORK ACTIVITY

Sitting

Standing

Light Labor

Heavy Labor

HABITS

Smoking Tobacco?

Current, how long, how many packs a day? _____

Former, how long?_____

Other forms of tobacco, how long? _____

Alcohol?

How many drinks per week? _____

Coffee/Caffeine Drinks?

How many per day? _____

High Stress Level?

Why? _____

How is most of your day spent? Standing Sitting Other _____

How old is your mattress? _____

Family History

If any blood relative has had any of the following conditions, please circle and indicate which relative(s):

ALCOHOLISM

ANEMIA

ARTERIOSCLEROSIS

ARTHRITIS

ASTHMA

BLEED EASILY

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Family History (continued)

If any blood relative has had any of the following conditions, please circle and indicate which relative(s):

CANCER
DIABETES
EMPHYSEMA
EPILEPSY
GLAUCOMA
HEART DISEASE
HIGH BLOOD PRESSURE
HIGH CHOLESTEROL
MULTIPLE SCLEROSIS
OSTEOPOROSIS
STROKE
THYROID DISEASE

Please Circle if you have/had any of the following:

AIDS/HIV
Alcoholism
Anemia
Appendicitis
Arteriosclerosis
Arthritis
Asthma
Bleeding Disorders
Bronchitis
Bursitis
Bruise Easily
Cancer
Cataracts
Chemical Dependency
Chicken Pox
Chest Pain
Colds
Colitis/Crohn's
Deafness
Depression
Diabetes
Difficulty Breathing
Diverticulosis
Dizziness
Eating Disorders
Eczema
Edema
Emphysema
Epilepsy
Fainting
Fatigue
Foot Pain/Issues
Fractures
Gallbladder Trouble
Glaucoma
Goiter
Gout
Heart Burn
Heart Disease
Hemorrhoids
Hepatitis
Hernia
Herniated Disc
High Blood Pressure
High Cholesterol
Hives/Allergies
Influenza
Irregular Pulse
Jaundice
Joint Pain
Kidney Disease
Liver Disease
Loss of Sleep
Low Back Pain
Low Blood Pressure
Malaria
Measles
Mental Illness
Mid Back Pain
Migraine/Headaches
Miscarriage
Mononucleosis
Multiple Sclerosis
Mumps
Muscle Weakness
Nasal Obstruction
Neck Pain
Nose Bleeds
Numbness/Tingling
Osteoporosis
Pacemaker
Pain Over Heart
Pain Over Heart
Palpitation
Parkinson's disease
Pinched Nerve
Pneumonia
Poor Circulation
Prostate Problems
Prosthesis
Psychiatric Care
Rash
Rapid Heart Beat
Ringing of the ears
Rheumatoid Arthritis
Rheumatic Fever
Scarlet Fever
Sexually Transmitted Disease
Sinus Infection
Slow Heart Beat
Stroke
Suicide Attempt
Swelling of Ankles
Thyroid Problems
Tonsillitis
Tremors
Tuberculosis
Tumors/Growths
Typhoid Fever
Ulcers
Varicose Veins
Vision Problems
Weight Loss/Gain
Whooping Cough