ANNAPOLIS FAMILY CHIROPRACTIC
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HEALTH HISTORY

NAME:_____DATE OF BIRTH:_____/_____/_____TODAY'S DATE:_____/_____/_____

HEIGHT:_____ WEIGHT:_____ PAIN LEVEL (CIRCLE ONE): 0 1 2 3 4 5 6 7 8 9 10
NO PAIN *SEVERE PAIN*

HISTORY OF PRESENT COMPLAINT

CHIEF COMPLAINT:_____

LOCATION:_____ QUALITY:_____
(Where is the pain/problem?) (How does it feel? Example: Achy, tight, sharp, numb, etc.)

SEVERITY:_____ DURATION:_____
(Mild, moderate, severe, very severe) (How long have you had this problem?)

TIMING:_____ CONTEXT:_____
(Does the pain/problem occur at a certain time?) (Where were you at the onset of this pain/problem?)

ASSOCIATED SYMPTOMS:_____ MODIFYING FACTORS:_____
(Does the pain/problem cause other symptoms?) (What makes the pain/problem better? What makes it worse?)

MEDICAL HISTORY

DIABETES	YES	NO	PLEASE LIST HOSPITALIZATIONS/SURGERIES/INJURIES
HYPERTENSION	YES	NO	_____
CANCER	YES	NO	_____
STROKE	YES	NO	_____
HEART TROUBLE	YES	NO	PLEASE LIST CURRENT MEDICATIONS:
ARTHRITIS/GOUT	YES	NO	_____
BLEEDING TENDENCY	YES	NO	_____
STOMACH PROBLEMS	YES	NO	_____

SOCIAL HISTORY

MARITAL STATUS: SINGLE MARRIED LEGALLY SEPARATED DIVORCED WIDOWED

USE OF ALCOHOL: NEVER RARELY MODERATE DAILY

USE OF TOBACCO: NEVER PREVIOUSLY, BUT QUIT CURRENT (LIST PACKS/DAY)_____

USE OF ILLICIT DRUGS: NEVER PREVIOUSLY CURRENT (LIST TYPE AND FREQUENCY)_____

DO YOU HAVE EXCESSIVE EXPOSURE TO: FUMES DUST SOLVENTS AIR-BORNE PARTICLES

DESCRIPTION OF EMPLOYMENT:_____

FAMILY MEDICAL HISTORY

	AGE	DISEASE	IF DECEASED, CAUSE OF DEATH
FATHER			
MOTHER			
SIBLINGS			

REVIEW OF SYSTEMS

CONSTITUTIONAL SYMPTOMS:		
GOOD GENERAL HEALTH	YES	NO
RECENT WEIGHT CHANGE	YES	NO
FEVER	YES	NO
FATIGUE	YES	NO
HEADACHES	YES	NO

EYES:		
EYE DISEASE OR INJURY	YES	NO
WEAR EYEGLASSES OR CONTACTS	YES	NO
BLURRED OR DOUBLE VISION	YES	NO
GLAUCOMA	YES	NO

EARS/NOSE/MOUTH/THROAT:		
HEARING LOSS OR RINGING	YES	NO
EARACHES OR DAMAGE	YES	NO
CHRONIC SINUS PROBLEMS	YES	NO
NOSE BLEEDS	YES	NO
MOUTH SORES	YES	NO
BLEEDING GUMS	YES	NO
SWOLLEN GLANDS	YES	NO

CARDIOVASCULAR:		
HEART TROUBLE OR ATTACK	YES	NO
CHEST PAIN	YES	NO
SHORTNESS OF BREATH	YES	NO
SWELLING OF FEET/ANKLES/HANDS	YES	NO

RESPIRATORY:		
CHRONIC OR FREQUENT COUGHS	YES	NO
SPITTING UP OF BLOOD	YES	NO
SHORTNESS OF BREATH	YES	NO
ASTHMA/WHEEZING	YES	NO

GASTROINTESTINAL:		
LOSS OF APPETITE	YES	NO
CHANGE IN BOWEL HABITS	YES	NO
NAUSEA OR VOMITING	YES	NO
FREQUENT DIARRHEA	YES	NO
CONSTIPATION	YES	NO
RECTAL BLEEDING/BLOODY STOOL	YES	NO
ABDOMINAL PAIN/HEARTBURN	YES	NO
PEPTIC ULCER	YES	NO

GENITOURINARY:		
FREQUENT URINATION	YES	NO
BURNING/PAINFUL URINATION	YES	NO
BLOOD IN URINE	YES	NO
DIFFICULTY STARTING/STOPPING	YES	NO
INCONTINENCE	YES	NO
KIDNEY STONES	YES	NO
SEXUAL DIFFICULTY	YES	NO
MALES:		
TESTICULAR PAIN	YES	NO
FEMALES:		
DATE OF LAST PAP SMEAR_____		
PAIN WITH PERIODS	YES	NO
IRREGULAR PERIODS	YES	NO
ABNORMAL VAGINAL DISCHARGE	YES	NO

OF PREGNANCIES_____ # OF MISCARRIAGES_____

MUSCULOSKELETAL:		
JOINT PAIN	YES	NO
JOINT STIFFNESS/SWELLING	YES	NO
WEAKNESS OF MUSCLES/JOINTS	YES	NO
MUSCLE PAIN OR CRAMPS	YES	NO
BACK PAIN	YES	NO
NECK PAIN	YES	NO
COLD EXTREMITIES	YES	NO
DIFFICULTY IN WALKING	YES	NO

INTEGUMENTARY:		
RASH OR ITCHING	YES	NO
CHANGE IN SKIN COLOR	YES	NO
CHANGE IN HAIR OR NAILS	YES	NO
VARICOSE VEINS	YES	NO
BREAST PAIN	YES	NO
BREAST LUMPS	YES	NO
BREAST DISCHARGE	YES	NO
BREAST CANCER	YES	NO

NEUROLOGICAL:		
FREQUENT/RECURRING HEADACHE	YES	NO
LIGHTHEADED OR DIZZINESS	YES	NO
CONVULSIONS OR SEIZURES	YES	NO
NUMBNESS/TINGLING SENSATION	YES	NO
TREMORS	YES	NO
PARALYSIS	YES	NO
STROKE	YES	NO
HEAD INJURY	YES	NO

PSYCHIATRIC:		
MEMORY LOSS OR CONFUSION	YES	NO
NERVOUSNESS	YES	NO
INSOMNIA	YES	NO
DEPRESSION	YES	NO

ENDOCRINE:		
GLANDULAR/HORMONE PROBLEMS	YES	NO
THYROID DISEASE	YES	NO
DIABETES	YES	NO
EXCESSIVE THIRST/URINATION	YES	NO
HEAT OR COLD TOLERANCE	YES	NO
SKIN BECOMING DRYER	YES	NO
CHANGE IN HAT OR GLOVE SIZE	YES	NO

HEMATOLOGIC/LYMPHATIC:		
SLOW TO HEAL AFTER CUTS	YES	NO
BLEEDING/BRUISING TENDENCY	YES	NO
ANEMIA	YES	NO
PHLEBITIS	YES	NO
PAST TRANSFUSION	YES	NO
ENLARGED GLANDS	YES	NO

ALLERGIC/IMMUNOLOGIC:		
HISTORY OF SKIN OR OTHER ADVERSE REACTION TO:		
PENICILLIN OR OTHER ANTIBIOTICS	YES	NO
MORPHINE, DEMEROL, NARCOTICS	YES	NO
NOVOCAINE OR ANESTHESIA	YES	NO
ASPIRIN OR OTHER PAIN MEDICATIONS	YES	NO
OTHER DRUGS OR FOODS	YES	NO