Innovation Wellness & Massage Ltd.

# PERSONAL HEALTH HISTORY

**Patient's Name** _____ **DOB** _____ **Date** _____

All information will be kept strictly confidential. Your responses will help determine if chiropractic treatment will benefit you. Unless we sincerely feel that your condition will respond satisfactorily, we will not recommend treatment. Please check the degree of all conditions you currently have or have had. To be responsible for your case, we need your complete health history.

**O = Occasional F = Frequent C = Constant**

**O F C**

**Muscle / Joint**
- ☐ ☐ ☐ Arthritis
- ☐ ☐ ☐ Bursitis
- ☐ ☐ ☐ Foot trouble
- ☐ ☐ ☐ Hernia
- ☐ ☐ ☐ Low back pain
- ☐ ☐ ☐ Lumbago
- ☐ ☐ ☐ Neck pain, stiffness
- ☐ ☐ ☐ Pain between shoulders

**General**
- ☐ ☐ ☐ Allergy
- ☐ ☐ ☐ Chills
- ☐ ☐ ☐ Convulsions
- ☐ ☐ ☐ Dizziness
- ☐ ☐ ☐ Fainting
- ☐ ☐ ☐ Fatigue
- ☐ ☐ ☐ Fever
- ☐ ☐ ☐ Headache
- ☐ ☐ ☐ Loss of sleep
- ☐ ☐ ☐ Loss of weight
- ☐ ☐ ☐ Nervousness, depression
- ☐ ☐ ☐ Neuralgia
- ☐ ☐ ☐ Numbness
- ☐ ☐ ☐ Sweats
- ☐ ☐ ☐ Tremors

**Cardiovascular**
- ☐ ☐ ☐ Hardening of arteries
- ☐ ☐ ☐ High blood pressure
- ☐ ☐ ☐ Low blood pressure
- ☐ ☐ ☐ Pain over heart
- ☐ ☐ ☐ Poor circulation
- ☐ ☐ ☐ Rapid heartbeat
- ☐ ☐ ☐ Slow heartbeat
- ☐ ☐ ☐ Swelling of ankles

**Genitourinary**
- ☐ ☐ ☐ Bed-wetting
- ☐ ☐ ☐ Blood in urine
- ☐ ☐ ☐ Frequent urination
- ☐ ☐ ☐ Lack of kidney control
- ☐ ☐ ☐ Kidney infection
- ☐ ☐ ☐ Painful urination
- ☐ ☐ ☐ Prostate trouble
- ☐ ☐ ☐ Pus in urine

**O F C**

**Eye, Ear, Nose and Throat**
- ☐ ☐ ☐ Asthma
- ☐ ☐ ☐ Colds
- ☐ ☐ ☐ Crossed eyes
- ☐ ☐ ☐ Deafness
- ☐ ☐ ☐ Dental decay
- ☐ ☐ ☐ Earache
- ☐ ☐ ☐ Ear discharge
- ☐ ☐ ☐ Ear noise
- ☐ ☐ ☐ Enlarged glands
- ☐ ☐ ☐ Enlarged thyroid
- ☐ ☐ ☐ Eye pain
- ☐ ☐ ☐ Failing vision
- ☐ ☐ ☐ Far sightedness
- ☐ ☐ ☐ Gum trouble
- ☐ ☐ ☐ Hay fever
- ☐ ☐ ☐ Hoarseness
- ☐ ☐ ☐ Nasal obstruction
- ☐ ☐ ☐ Near sightedness
- ☐ ☐ ☐ Nose bleeds
- ☐ ☐ ☐ Sinus infection
- ☐ ☐ ☐ Sore throat
- ☐ ☐ ☐ Tonsillitis

**Gastrointestinal**
- ☐ ☐ ☐ Belching or gas
- ☐ ☐ ☐ Colitis
- ☐ ☐ ☐ Colon trouble
- ☐ ☐ ☐ Constipation
- ☐ ☐ ☐ Diarrhea
- ☐ ☐ ☐ Difficult digestion
- ☐ ☐ ☐ Bloated abdomen
- ☐ ☐ ☐ Excessive hunger
- ☐ ☐ ☐ Gallbladder trouble
- ☐ ☐ ☐ Hemorrhoids
- ☐ ☐ ☐ Intestinal worms
- ☐ ☐ ☐ Jaundice
- ☐ ☐ ☐ Liver trouble
- ☐ ☐ ☐ Nausea
- ☐ ☐ ☐ Pain over stomach
- ☐ ☐ ☐ Poor appetite
- ☐ ☐ ☐ Vomiting
- ☐ ☐ ☐ Vomiting of blood

**O F C**

**Skin**
- ☐ ☐ ☐ Boils
- ☐ ☐ ☐ Bruise easily
- ☐ ☐ ☐ Dryness
- ☐ ☐ ☐ Hives or allergy
- ☐ ☐ ☐ Itching
- ☐ ☐ ☐ Skin eruptions (rash)
- ☐ ☐ ☐ Varicose veins

**Pain or numbness in**
- ☐ ☐ ☐ Shoulders
- ☐ ☐ ☐ Arms
- ☐ ☐ ☐ Elbows
- ☐ ☐ ☐ Hand
- ☐ ☐ ☐ Hips
- ☐ ☐ ☐ Legs
- ☐ ☐ ☐ Knees
- ☐ ☐ ☐ Feet
- ☐ ☐ ☐ Painful tailbone
- ☐ ☐ ☐ Poor posture
- ☐ ☐ ☐ Sciatica
- ☐ ☐ ☐ Spinal curvature
- ☐ ☐ ☐ Swollen joints

**Respiratory**
- ☐ ☐ ☐ Chest pain
- ☐ ☐ ☐ Chronic cough
- ☐ ☐ ☐ Difficult breathing
- ☐ ☐ ☐ Spitting up blood
- ☐ ☐ ☐ Spitting up phlegm
- ☐ ☐ ☐ Wheezing

**Women only**
- ☐ ☐ ☐ Congested breasts
- ☐ ☐ ☐ Cramps or backache
- ☐ ☐ ☐ Excess menstrual flow
- ☐ ☐ ☐ Hot flashes
- ☐ ☐ ☐ Irregular cycle
- ☐ ☐ ☐ Lumps in breast
- ☐ ☐ ☐ Menopause
- ☐ ☐ ☐ Painful menstruation
- ☐ ☐ ☐ Vaginal discharge

Are you pregnant? ☐Yes ☐No
If yes, how many months?____
How many children do you have?____

*Check any of the following conditions you currently have or have had:*
- ☐ Alcoholism
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Cancer
- ☐ Chicken pox
- ☐ Cholera
- ☐ Cold sores
- ☐ Diabetes
- ☐ Diptheria
- ☐ Eczema
- ☐ Edema
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fever blisters
- ☐ Goiter
- ☐ Gout
- ☐ Heart disease
- ☐ Herpes
- ☐ Influenza
- ☐ Lumbago
- ☐ Malaria
- ☐ Measles
- ☐ Miscarriage
- ☐ Multiple sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pleurisy
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic fever
- ☐ Scarlet fever
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Typhoid fever
- ☐ Ulcers
- ☐ Venereal disease
- ☐ Whooping cough

**Describe chiropractic problem:** _____

_____

How long have you had this condition? Is it getting worse? ☐ Yes ☐ No

Does it bother your (check appropriate box): ☐ Work ☐ Sleep ☐ Other (please specify)

What seemed to be the initial cause?

Have you seen a chiropractor before? ☐ Yes ☐ No If yes, how long ago? _____
For what reason?

Are you under the care of a physician? ☐ Yes ☐ No If yes, for what reason?

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| |
|---|
| Have you been hospitalized in the last 5 years? ☐ Yes ☐ No If yes, for major surgery? ☐ Yes ☐ No for serious injury? ☐ Yes ☐ No |
| Have you had any mental or emotional disorders? ☐ Yes ☐ No If yes, when? |
| Indicate the drugs do you now take? ☐ birth control pills ☐ tranquilizers ☐ pain killers ☐ other (specify) |
| Do you wear: ☐ heel lifts? ☐ sole lifts? ☐ inner soles? ☐ area supports? ☐ negative heels? ☐ platform shoes? |
| What is the age of your mattress? Is it ☐ comfortable? ☐ uncomfortable? Do you use a bedboard? ☐ Yes ☐ No |
| How is most of your day spent? ☐ standing ☐ sitting ☐ walking ☐ other (specify) |

| **Have you ever:** | Yes | No | If yes, briefly explain. |
|---|---|---|---|
| - had a broken bone? | ☐ | ☐ | |
| - been hospitalized? | ☐ | ☐ | |
| - had strains or sprains? | ☐ | ☐ | |
| - used a cane, crutch or other support? | ☐ | ☐ | |
| - been struck unconscious? | ☐ | ☐ | |
| - been hospitalized for other than surgery? | ☐ | ☐ | |
| **Do you:** | | | |
| - take minerals, herbs or vitamins? | ☐ | ☐ | |
| - think you need minerals, herbs or vitamins? | ☐ | ☐ | |
| - have any drug allergy? | ☐ | ☐ | |

| **When did you last have:** | Never | 0-6 mos. | 6 -18 mos. | longer |
|---|---|---|---|---|
| - spinal x-ray? | ☐ | ☐ | ☐ | ☐ |
| - spinal examination? | ☐ | ☐ | ☐ | ☐ |
| - physical examination? | ☐ | ☐ | ☐ | ☐ |

| **HABITS** | None | Light | Mod | Heavy |
|---|---|---|---|---|
| Alcohol | ☐ | ☐ | ☐ | ☐ |
| Coffee | ☐ | ☐ | ☐ | ☐ |
| Tobacco | ☐ | ☐ | ☐ | ☐ |
| Drugs | ☐ | ☐ | ☐ | ☐ |
| Exercise | ☐ | ☐ | ☐ | ☐ |
| Sleep | ☐ | ☐ | ☐ | ☐ |
| Appetite | ☐ | ☐ | ☐ | ☐ |
| Soft Drinks | ☐ | ☐ | ☐ | ☐ |
| Salty Foods | ☐ | ☐ | ☐ | ☐ |
| Water | ☐ | ☐ | ☐ | ☐ |
| Sugar | ☐ | ☐ | ☐ | ☐ |
| Artificial Sweeteners | ☐ | ☐ | ☐ | ☐ |

Please list any other health conditions you have been treated for, or surgery you have had in the last ten years.

_____

_____

**FAMILY HEALTH HISTORY:** Information about your immediate family members, brothers, sisters, parents, and grandparents will give us a better understanding of your total health picture.

| RELATIONSHIP | PRESENT AND PAST HEALTH PROBLEMS |
|---|---|
| | |
| | |
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| | |

Please mark your areas of pain on the figures below.