

# PERSONAL HISTORY

Date: \_\_\_\_\_ E-mail add.: \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

Name: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Sex: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Name Of Your Employer: \_\_\_\_\_ Type Of Work: \_\_\_\_\_

Circle If You Are: Married Single Widowed Divorced Separated

Name and Telephone # of Person to Contact in Case of Emergency: \_\_\_\_\_

Name Of Husband Or Wife: \_\_\_\_\_

Husband Or Wife's Employer: \_\_\_\_\_

Ages Of Your Children: \_\_\_\_\_

Referred To This Office By: \_\_\_\_\_

Who Is Responsible For Your Bill? ( ) Self ( ) Husband or Wife ( ) Employer  
( ) Insurance ( ) Other: \_\_\_\_\_

## PAST HEALTH HISTORY

PLEASE CHECK APPLICABLE ITEMS.

### OPERATIONS:

Appendectomy \_\_\_\_\_ Rectal \_\_\_\_\_ Tonsillectomy \_\_\_\_\_

Gall Bladder \_\_\_\_\_ Female Organs \_\_\_\_\_ Hernia \_\_\_\_\_

Others: \_\_\_\_\_

### VACCINATIONS & INJECTIONS:

Diphtheria \_\_\_\_\_ Polio \_\_\_\_\_ Tetanus \_\_\_\_\_

Typhoid \_\_\_\_\_ Small Pox \_\_\_\_\_ Spinal Tap or Injection \_\_\_\_\_

**ACCIDENTS OR FALLS:** (Please describe) \_\_\_\_\_

**FRACTURES OR DISLOCATIONS:** \_\_\_\_\_

### HABITS:

Sleep (hours) \_\_\_\_\_ Coffee \_\_\_\_\_ Tea \_\_\_\_\_ Alcohol \_\_\_\_\_

Tobacco \_\_\_\_\_ Exercise \_\_\_\_\_ Hobbies \_\_\_\_\_

Are you now taking any drugs? (Please name) \_\_\_\_\_

Have you ever had a nervous breakdown? \_\_\_\_\_

Have you or any member of your family been treated for a mental disorder? \_\_\_\_\_

**CIRCLE ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:**

Appendicitis  
Scarlet Fever  
Diphtheria  
Typhoid Fever  
Pneumonia  
Rheumatic Fever  
Polio  
Hepatitis B  
Hepatitis C

Malaria  
Tuberculosis  
Whooping Cough  
Anemia  
Measles  
Mumps  
Small Pox  
Herpes

Chicken Pox  
Diabetes  
Cancer  
Heart Disease  
Goiter  
Influenza  
Pleurisy  
HIV

Alcoholism  
Venereal Infection  
Arthritis  
Epilepsy  
Mental Disorder  
Lumbago  
Eczema  
AIDS

**Please Underline All Of The Following Symptoms You Have Had Previously.**

**Please Circle All Of The Following Symptoms You Have Now.**

**GENERAL SYMPTOMS**

Headache  
Fever  
Chills  
Sweats  
Fainting  
Dizziness  
Convulsions  
Loss of Sleep  
Fatigue  
Nervousness  
Loss of Weight  
Numbness or pain in arms,  
hands, or legs  
Allergy  
Wheezing  
Neuralgia

**E.E.N.T.**

Failing vision  
Near sightedness  
Far sightedness  
Crossed eyes  
Eye pain  
Deafness  
Earache  
Ear noises  
Ear discharge  
Nose bleeds  
Nasal obstruction  
Sore throat  
Hoarseness  
Asthma  
Dental decay  
Gum trouble  
Frequent colds  
Enlarged thyroid  
Tonsillitis  
Sinus infection  
Nasal drainage  
Enlarged glands  
Hay fever

**SKIN**

Skin Eruptions  
Itching  
Bruises easily  
Dryness  
Boils  
Varicose Veins  
Sensitive Skin  
Hives or Allergy

**RESPIRATORY**

Chronic cough  
Spitting up phlegm  
Spitting up blood  
Chest pain  
Difficult breathing

**CARDIO-VASCULAR**

Rapid beating heart  
Slow beating heart  
High blood pressure  
Low blood pressure  
Pain over heart  
Previous heart stroke  
Hardening of arteries  
Swelling of ankles  
Poor circulation  
Paralytic stroke

**MUSCLE & JOINT SYMP.**

Stiff neck  
Backache  
Swollen joints  
Tremors  
Painful tail bone  
Foot trouble  
Pain between shoulders  
Hernia  
Spinal curvature  
Faulty posture

**GENITOURINARY SYMPTOMS**

Frequent urination  
Painful urination  
Blood in urine  
Pus in urine  
Kidney Infection or Stones  
Bed Wetting  
Inability To Control Urine  
Prostate Trouble

**GASTROINTESTINAL SYMPTOMS**

Poor appetite  
Difficult digestion  
Excessive hunger  
Belching or gas  
Nausea  
Vomiting  
Vomiting of blood  
Pain over stomach  
Distention of abdomen  
Constipation  
Diarrhea  
Colon trouble  
Hemorrhoids (Piles)  
Intestinal worms  
Liver trouble  
Gall bladder trouble  
Jaundice  
Colitis

**FOR WOMEN ONLY**

Painful menstrual periods  
Excessive flow  
Hot flashes  
Irregular cycle  
Cramps or backache  
Previous miscarriage  
Vaginal discharge  
Lumps in breast  
Menopausal symptoms  
Are you pregnant?

Yes  No

## FAMILY HEALTH HISTORY

FAMILY HISTORY: Among your blood relatives, did anyone have the following?

	YES	NO	Relation		YES	NO	Relation
1. Cancer	___	___	_____	6. Diabetes	___	___	_____
2. Heart Disease	___	___	_____	7. Nervous or	___	___	_____
3. High Blood Pressure	___	___	_____	Mental Disease	___	___	_____
4. Stroke	___	___	_____	8. Asthma	___	___	_____
5. Tuberculosis	___	___	_____	9. Convulsions	___	___	_____

Parents living \_\_\_\_\_ Brothers living \_\_\_\_\_ Sisters living \_\_\_\_\_  
 If dead, give relationship and cause of death \_\_\_\_\_

## INSURANCE

Nearly all insurance policies provide chiropractic coverage, but benefits vary from company to company and from policy to policy. Therefore, although we will fill out the insurance forms, the patient is personally responsible for payment of the bill. We do accept certain insurance assignments but all insurance arrangements must be approved in advance with the business office.

Check type of insurance coverage:

- |  |   |
|--|---|
| <input type="checkbox"/> Workman's Compensation<br><input type="checkbox"/> Government Health Plan<br><input type="checkbox"/> Personal Policy | <input type="checkbox"/> Automobile Insurance Policy<br><input type="checkbox"/> Group Policy<br><input type="checkbox"/> Other |
|--|---|

X \_\_\_\_\_  
 PATIENT'S SIGNATURE

**Do Not Write Below This Line**

---