FAMILY CHIROPRACTIC CENTER FAYETTEVILLE 114 South College Ave, Suite A, Fayetteville, Arkansas 72701 479-442-0676

Health History Form

Name_____ Date_____

Main Problem

What pain causes you to come to the office? _____

What caused this pain? _____ Last Episode _____

When did this pain start? _____ How long does this pain last? _____

How bad is this pain? (Circle the one that applies) Mild, Moderate, Severe, Intolerable

Circle the word or words that best describe the pain. Cramping, Aching, Dull, Sharp, Shooting, Bright, Diffuse, Lighteninglike, Throbbing, Nagging, Burning, Deep, Stinging, Pressurelike

How often does the pain occur? (Circle the one that applies) Occasional, Frequent, Constant

Does this pain travel to any other area? _____

What makes this pain better? _____

What makes this pain worse? _____

What else have you done to treat this pain? _____

Other Problems

What other problems or pain do you have? _____

What caused this pain? _____ Last Episode _____

When did this pain start? _____ How long does this pain last? _____

How bad is this pain? (Circle the one that applies) Mild, Moderate, Severe, Intolerable

Circle the word or words that best describe the pain. Cramping, Aching, Dull, Sharp, Shooting, Bright, Diffuse, Lighteninglike, Throbbing, Nagging, Burning, Deep, Stinging, Pressurelike

How often does the pain occur? (Circle the one that applies) Occasional, Frequent, Constant

Does this pain travel to any other area? _____

What makes this pain better? _____

What makes this pain worse? _____

What else have you done to treat this pain? _____

Allergies

Please list any allergies below.

Medication Allergies _____

_____

Other Allergies _____

_____

Name_____ **Health History Page 2**

Family History

Please tell us about your health and the health of your grandparents, your parents, and your siblings. Circle or check everything that applies. If someone is Deceased, please check or write in the cause.

		Heart Disease	Stroke	Cancer	Diabetes	Rheumatoid Arthritis	Multiple Sclerosis	Lung Disease	Other
Yourself									
	Living Deceased								
Paternal Grandfather	L D Cause								
Paternal Grandmother	L D Cause								
Maternal Grandfather	L D Cause								
Maternal Grandmother	L D Cause								
Father	L D Cause								
Mother	L D Cause								
Sibling M F	L D Cause								
Sibling M F	L D Cause								
Sibling M F	L D Cause								

Social History

Are you employed **Y N** Where_____ What do you do_____

Do you Drink Caffeine? **Y N** type/freq _____ Do you Drink Alcohol? **Y N** type/ freq _____

Do you Smoke? **Y N** ___ Cigarettes per day Previous Smoker **Y N** Date Quit _____

Other Tobacco? **Y N** type/ freq _____ Do you use Recreational Drugs? **Y N** Exercise **Y N** type/ freq _____

Past History

Have you had any illnesses in the past _____

_____

Have you had any injuries _____

_____

Have you been hospitalized _____

Have you had any surgeries _____

List **ALL Medications** that you are taking _____

_____

Females: Are you Pregnant? **Yes No** **Expected Due Date** _____ **How many Children?** _____

I certify that the information that I have given here is true and accurate to the best of my knowledge.

Signed _____ **Date** _____