Confidential Health History
Returning Patients

Since it has been a while since your last visit, please complete this form so that we have your most current health and contact information on file.

Personal Information:

Last Name:_____ First Name: _____

Address:_____ City: _____ Postal Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Occupation: _____ Employer: _____

Names and ages of children: _____

E-mail address:_____

Health Information:

Which best describes your reason for returning to our office?

□ I have a specific concern and require help only with this concern
□ I want to ensure that my health concerns do not become an ongoing problem that will impact my future health
□ I want to be healthier five years from now than I am today
□ Other reasons_____

_____

Have there been any changes in your health since we last saw you?

_____

Have you had any surgeries since we last saw you?

_____

Have you had an injury or been involved in any accidents since we last saw you?

_____

Medications: □Pain Meds □Birth Control □Heart Meds □Cholesterol Meds □Other _____

Lifestyle Information:

Do you exercise? □ Yes □ No If yes, how much and how often? _____

Do you smoke? □ Yes □ No If yes, how much? _____

Do you consume alcohol? □ Yes □ No If yes, how much and how often? _____

Do you drink water? □ Yes □ No If yes, how much per day? _____

Health History:

Have you experienced any of the following since we last saw you?

Allergies	□ Yes □ No	Heart Condition	□ Yes □ No
Anxiety	□ Yes □ No	Immune System Disorder	□ Yes □ No
Arthritis	□ Yes □ No	Infertility	□ Yes □ No
Asthma	□ Yes □ No	Kidney Disease	□ Yes □ No
Back Pain	□ Yes □ No	Menstrual Cramps	□ Yes □ No
Bladder Problems	□ Yes □ No	Mood Swings	□ Yes □ No
Cancer	□ Yes □ No	Neck Pain	□ Yes □ No
Circulatory/Vascular Disorder	□ Yes □ No	Numbness/Tingling	□ Yes □ No
Depression	□ Yes □ No	Osteoporosis	□ Yes □ No
Diarrhea	□ Yes □ No	Sinus Trouble	□ Yes □ No
Digestive Problems	□ Yes □ No	Skin Conditions	□ Yes □ No
Dizziness	□ Yes □ No	Urinary Difficulty	□ Yes □ No
Headaches	□ Yes □ No	Vertigo	□ Yes □ No
Heartburn/Reflux	□ Yes □ No	Other: _____	□ Yes □ No

Stress History:

Please indicate whether you have experienced stress in any of the following areas since we last saw you? Your answers will enable us to determine which factors have contributed to your present health concerns.

Alcohol Consumption	□ Yes □No	Inhaler Use	□ Yes □ No
Repeated/Prolonged Antibiotic Use	□ Yes □No	Prescription Medications	□ Yes □ No
Car Accident	□ Yes □No	Smoker	□ Yes □ No
Coffee Drinker	□ Yes □No	Surgery	□ Yes □ No
Contact Sports	□ Yes □No	Extreme Sports	□ Yes □ No
Fall/Jump from a Height	□ Yes □No	Workplace Stress	□ Yes □ No
Head Trauma	□ Yes □No	Other Traumas (physical or emotional)	
Home Environment Stress	□ Yes □No	_____	

Your Goals:

What are your objectives in returning to our office for chiropractic care? (please check all that apply)

- □ Relief of symptoms
- □ Decrease the risk of symptoms returning
- □ Decrease the risk of re-injury
- □ Improve range of motion/mobility
- □ Improve spinal stability
- □ Improve nerve function
- □ Increase energy level
- □ Relieve stress
- □ Decrease the risk of arthritis
- □ Improve overall health and well-being
- □ Other (please list):

_____

_____ _____ _____

Name Signature Date