The Chiropractic Health & Wellness Center of Dayton, Inc.

Revised 04/2007

PATIENT HISTORY FORM-CONFIDENTIAL

Name:_____ Date:_____

Past Medical History (check all that currently or previously apply to you personally):

System Review:

- ☐ High blood pressure
- ☐ Heart Attack
- ☐ Diabetes - Type I or Type II (Circle)
- ☐ Headaches (specify)_____
- ☐ Cancer (specify) _____
- ☐ Stroke / TIA
- ☐ Asthma
- ☐ **Pacemaker / Arterial Stent(s)**
- ☐ Skin Cancer or Lesions
- ☐ Lymphoma
- ☐ Leukemia
- ☐ Prostatitis / Elevated PSA
- ☐ Endometriosis
- ☐ Sleep Apnea
- ☐ Anxiety / Depression (please circle)
- ☐ Allergies(specify)_____
- ☐ Stomach Ulcers
- ☐ Lung Disease / COPD
- ☐ Liver Disease(specify)_____
- ☐ Kidney Disease(specify)_____
- ☐ Hyperthyroid
- ☐ Hypothyroid

☐ Autoimmune / Inherited Condition (Ex. Blood Disorders, Polio, Chron's Disease, IBS, Paget's disease)
If yes, please list:_____

List All Family History:_____

(Office use only)_____

_____

Musculoskeletal Review:

- ☐ Gout
- ☐ Osteoporosis
- ☐ Arthritis
- ☐ Scoliosis
- ☐ Psoriasis / Psoriatic Arthritis
- ☐ Disc Degeneration
- ☐ Bone Spurs
- ☐ Rheumatoid Arthritis
- ☐ Ankylosing Spondylitis
- ☐ Lupus
- ☐ Fibromyalgia
- ☐ Reiter's Syndrome
- ☐ Reynaud's
- ☐ TMJ / Bruxism (Jaw clenching)
- ☐ Double Vision
- ☐ Weakness
- ☐ Neuropathy
- ☐ Peripheral Circulatory Problems
- ☐ Swelling of the hands or feet (specify)
- ☐ Coldness of the hands or feet (specify)
- ☐ Foot Drop / Weakness
- ☐ Dizziness / Vertigo
- ☐ Facial Numbness or Pain
- ☐ Multiple Sclerosis
- ☐ Other:_____

☐ Medical / Artificial Implants / Previous Bone Fractures
If yes, please list:_____

☐ Recent steroid injections / current corticosteroid prescription

Do you have Hepatitis B / Hepatitis C / Tuberculosis or HIV infection (Circle any that apply)

Please indicate if you use the following substances:

Tobacco	_____Never	_____Rarely	_____Daily	_____(amount)
Alcohol	_____Never	_____Rarely	_____Daily	_____(amount)
Recreational Drugs	_____Never	_____Rarely	_____Daily	_____(amount)
Caffeine / Carbonated soda	_____Never	_____Rarely	_____Daily	_____(ounces per day) ☐ **Diet Soda**

Please *list all* previous trauma / auto accidents / surgeries & hospitalizations with dates and treatment:_____

_____

_____

_____

Please list all current medications / dietary supplements / all routine exercise & physical activities:

_____

_____

_____

What is your dominant Hand (please circle): R / L

What position do you commonly sleep in?_____

Are you pregnant? YES / NO

How many hours do you sleep at night?_____

 # Of children and their respective ages:_____

What is your current stress level (1(no stress) – 10(intolerable stress))_____