CONFIDENTIAL HEALTH HISTORY

Core Wellness
Chiropractic and Anti-Aging Centre

Date:_____

Name:_____

Place an X if you have **EVER HAD** or **HAVE** that symptom:

GENERAL
____Fever/Chills
____Headaches
____Migraine
____Tension
____Sinus
____Night Sweats
____Loss Of Sleep
____Fatigue
____Nervousness
____Weight Loss/Gain
____Allergies/Allergy Shots
____Diabetes
____Cancer
____Thyroid/Goiter Issues
____HIV/AIDS

EAR/EYE/NOSE/THROAT
____Vision Problems
____Pain In Eye(s)
____Hearing Problems
____Nose Bleeds
____Sinus Problems
____Hoarseness
____Tonsillitis/Removal

RESPIRATORY
____Difficulty Breathing
____Chronic Cough
____Spitting Phlegm/Blood
____Emphysema
____Wheezing/Asthma
____Pneumonia
____Tuberculosis

CARDIOVASCULAR
____Anemia
____High/Low Blood Pressure
____High Cholesterol
____Pain Over Heart
____Heart Trouble/Disease
____Ankle Swelling
____Varicose Veins
____Rheumatic Fever
____Stroke
____Pace Maker

GENITOURINARY
____Urination problems
____Painful
____Frequent
____Difficult to start
____Difficult to control
____Bloody
____Kidney Disease
____Urinary Infections
____Sexual Difficulties
____Breast Lump/Pain

NEUROLOGICAL
____Weakness
____Twitching/Tremors
____Multiple Sclerosis
____Fainting
____Dizziness
____Epilepsy
____Numbness/Tingling
____Arm/leg Pain
____Psychological Disorder
____Parkinson's Disease
____Pinched Nerve

MUSCULOSKELETAL
____Neck Discomfort/Pain
____Osteoporosis
____Low Back Pain
____Swollen Joints
____Painful Joints
____Muscle Aches/Soreness
____Spinal Curvature/Scoliosis
____Broken Bones
____Arthritis
____Rheumatoid
____Osteoarthritis

GASTROINTESTINAL
____Poor Appetite
____Digestive Problems
____Belching/Gas
____Difficulty Swallowing
____Nausea/Vomiting
____Pain In Abdomen
____Ulcer
____Black/Bloody stool
____Liver Problems/Hepatitis
____Gall Bladder Problems
____Hernia
____Diarrhea/Constipation
____Appendicitis
____Bulimia/Anorexia

SKIN
____Itching
____Bruise Easily
____Change In Mole/Birthmark

MEN ONLY
____Testicular Swelling/Pain
____Prostate Problems

WOMEN ONLY
____Menstruation Problems
____Irregular
____Excessive
____Painful
____Vaginal Infections
____Miscarriage

Date last period began

_____

Date of last PAP test

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Date:_____

Name:_____

FAMILY HISTORY

	Siblings	Parents	Grandparents
Diabetes	_____	_____	_____
Heart Disease	_____	_____	_____
Nerve Disease	_____	_____	_____
Thyroid Dysfunction	_____	_____	_____
Cancer	_____	_____	_____
Kidney Disease	_____	_____	_____
Muscle Disease	_____	_____	_____
High Blood Pressure	_____	_____	_____
Bone Disease	_____	_____	_____

PERSONAL HISTORY

Childhood Diseases: Measles____ Mumps____ Chicken Pox____ Other_____

Unusual Childhood Diseases:_____

Adult Illnesses or Conditions:_____

Surgeries, Hospitalizations, or Fractures:_____

_____

Have you been treated for any health condition in the past year? Yes____ No____

If yes, please describe:_____

Results of previous treatment and tests performed: □ None □ Describe

_____

Any other major accidents or injuries that the doctor should know about?_____

_____

Medications & supplements you are currently taking □ No Medications □ Medications Taken:

_____

Allergies □ No Allergies □ Allergic To:_____

Date of last:

Physical Exam_____ Spinal X-ray_____ Blood Test_____
Spinal Exam_____ Chest X-ray _____ Urine Test_____
Dental X-ray_____ MRI/CT/Bone Scan_____

SOCIAL HISTORY Indicate how often you do the following: Often (O) Sometimes (S) Never (N)

____Vigorous Exercise ____Tobacco Use ____Financial Pressures
____Moderate Exercise ____Caffeine Use ____Other Mental Stresses
____Alcohol Use ____Family Pressures _____