Health History and Injury Form

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Name _____ Date _____ DOB _____

Address _____ City _____ State _____ Zip _____

Phone (H) _____ Phone (C) _____ E-Mail _____

What is your major health concern? _____

When did it start? _____

Have you had a similar condition before? _____
If yes, when? _____

Have you received any previous chiropractic care? _____
If yes, date of last visit, chiropractor's name, and reason for previous chiropractic care. _____

List any other current health problems. _____

Medical History

Surgeries	Date	Hospital

Other Hospitalizations	Date	Hospital

Medications	Dosage	Frequency

GENERAL SYMPTOMS (Check as many as apply)

☐ Nervousness	☐ Irritability	☐ Fatigue
☐ Depression	☐ Loss of sleep	☐ Tension
☐ PMS	☐ Jaw Pain	☐ Light headed
☐ Memory loss	☐ Fainting	

HEAD (Check as many as apply)

Headaches	Location	
☐ Sharp	☐ Back of head	☐ Forehead
☐ Dull	☐ Temples	☐ Behind eyes
☐ Migraine	☐ Right side	☐ Left side

Mild Extreme
Pain Level: ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
Frequency: ☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100%

SHOULDER (Check as many as apply)

Pain in joint	☐ Right	☐ Left
Pain across shoulder	☐ Right	☐ Left
Limitation of movement	☐ Right	☐ Left
Tension	☐ Right	☐ Left

Mild Extreme
Pain Level: ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
Frequency: ☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100%

NECK (Check as many as apply)

Neck Pain	☐ Right	☐ Left
Neck stiffness	☐ Right	☐ Left
Muscle spasms	☐ Right	☐ Left

Pain is increased by:	☐ Forward movement	☐ Backward movement
	☐ Right head rotation	☐ Left head rotation
	☐ Bending head right	☐ Bending head left

Mild Extreme
Pain Level: ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
Frequency: ☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100%

MIDBACK (Check as many as apply)

Pain between shoulder blades	☐ Right	☐ Left
Muscle spasms	☐ Right	☐ Left

Mild Extreme
Pain Level: ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
Frequency: ☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100%

ARM (Check as many as apply)

Pain in upper arm	☐ Right	☐ Left
Pain in elbow	☐ Right	☐ Left
Pain in forearm	☐ Right	☐ Left
Pins & Needles in arm	☐ Right	☐ Left
Pins & Needles in forearm	☐ Right	☐ Left

Mild Extreme
Pain Level: ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
Frequency: ☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100%

LOW BACK (Check as many as apply)

Upper lumbar pain	☐ Right	☐ Left
Lower lumbar pain	☐ Right	☐ Left
Muscle spasms	☐ Right	☐ Left
Pain over kidneys	☐ Right	☐ Left

Mild Extreme
Pain Level: ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
Frequency: ☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100%

HAND (Check as many as apply)

Wrist pain	☐ Right	☐ Left
Hand pain	☐ Right	☐ Left
Pins & Needles in hand	☐ Right	☐ Left
Numbness in hand	☐ Right	☐ Left

Mild Extreme
Pain Level: ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
Frequency: ☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100%

CHEST (Check as many as apply)

Pain around ribs	☐ Right	☐ Left
Deep chest pain	☐ Right	☐ Left
	☐ Irregular heart beat	☐ Shortness of breath

Mild Extreme
Pain Level: ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
Frequency: ☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100%

ABDOMINAL (Check as many as apply)

☐ Nervous stomach	☐ Nausea	☐ Gas
☐ Constipation	☐ Diarrhea	☐ Heartburn
☐ Indigestion	☐ Loss of appetite	☐Pain in stomach

Mild Extreme
Pain Level: ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
Frequency: ☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100%

FEET (Check as many as apply)

Ankle / foot pain	☐ Right	☐ Left
Numbness of feet	☐ Right	☐ Left
Ankle / foot swelling	☐ Right	☐ Left
Foot cramps	☐ Right	☐ Left

Mild Extreme
Pain Level: ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
Frequency: ☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100%

HIPS & LEGS (Check as many as apply)

Pain in buttocks	☐ Right	☐ Left
Pain in hip joint	☐ Right	☐ Left
Pain down leg	☐ Right	☐ Left
Pins & Needles in leg	☐ Right	☐ Left
Pain in knee	☐ Right	☐ Left
Leg cramps	☐ Right	☐ Left

Mild Extreme
Pain Level: ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
Frequency: ☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100%

EYES (Check as many as apply)

☐ Double vision	☐ Blurred vision	☐ Tired eyes
☐ Excessive tearing	☐ Dry eyes	☐ Light sensitive

EARS, NOSE, THROAT (Check as many as apply)

☐ Loss of hearing	☐ Loss of balance	☐ Ringing in ears
☐ Dizziness	☐Vertigo	☐ Frequent colds
☐ Sinusitis	☐ Pain in throat	☐ Nose bleeds
☐ Difficulty swallowing		

URINARY (Check as many as apply)

☐ Difficulty starting urination	☐ Blood in urine
☐ Pain or burning on urination	☐ Cloudy urine

VENEREAL DISEASE (Check as many as apply)
☐ AIDS ☐ Syphilis ☐ Gonorrhea ☐ Other _____

SOCIAL HISTORY (Check as many as apply)
☐ Smoking ☐ Coffee ☐ Tea ☐ Alcohol ☐ Recreational drug use

FAMILY STRESS (Check as many as apply)
☐ Severe ☐ Moderate ☐ Minimal ☐ None

JOB STRESS (Check as many as apply)
☐ Severe ☐ Moderate ☐ Minimal ☐ None

WOMEN ONLY (Check as many as apply)

☐ Painful period	☐ Vaginal discharge
☐ Irregular periods	☐ Lumps in breast

# of pregnancies_____ # of deliveries _____