

THE CONNECT CHIROPRACTIC

1210 6th St. Ste. #103

Nevada, Iowa 50201

GENERAL HEALTH HISTORY

Patient Name _____

Mark the conditions that apply to you.

- | Past | Present | Past | Present |
|--------------------------|--|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> Headaches | <input type="checkbox"/> | <input type="checkbox"/> Urinary Problems |
| <input type="checkbox"/> | <input type="checkbox"/> Migraines | <input type="checkbox"/> | <input type="checkbox"/> Easy Bruising |
| <input type="checkbox"/> | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> | <input type="checkbox"/> Tobacco Use |
| <input type="checkbox"/> | <input type="checkbox"/> Allergies / Asthma | <input type="checkbox"/> | <input type="checkbox"/> Dental Problems |
| <input type="checkbox"/> | <input type="checkbox"/> Medication Side Effects | <input type="checkbox"/> | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> | <input type="checkbox"/> Diabetes | <input type="checkbox"/> | <input type="checkbox"/> Blood Thinner use |
| <input type="checkbox"/> | <input type="checkbox"/> Hands or Feet cold | <input type="checkbox"/> | <input type="checkbox"/> HIV Positive |
| <input type="checkbox"/> | <input type="checkbox"/> Muscle aches | <input type="checkbox"/> | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> | <input type="checkbox"/> Trouble Walking | <input type="checkbox"/> | <input type="checkbox"/> Depression |
| <input type="checkbox"/> | <input type="checkbox"/> Leg / Foot Numbness | <input type="checkbox"/> | <input type="checkbox"/> Alcohol Use |
| <input type="checkbox"/> | <input type="checkbox"/> Fainting | <input type="checkbox"/> | <input type="checkbox"/> ___High or ___Low Blood Pressure |
| <input type="checkbox"/> | <input type="checkbox"/> Gall Bladder Trouble | <input type="checkbox"/> | <input type="checkbox"/> Stroke History |
| <input type="checkbox"/> | <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> | <input type="checkbox"/> Ear Problems | <input type="checkbox"/> | <input type="checkbox"/> TMJ |
| <input type="checkbox"/> | <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> | <input type="checkbox"/> Digestive Problems |
| <input type="checkbox"/> | <input type="checkbox"/> Vision Problems | <input type="checkbox"/> | <input type="checkbox"/> Pain all Over |
| <input type="checkbox"/> | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> | <input type="checkbox"/> Tension / Irritability |
| <input type="checkbox"/> | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> | <input type="checkbox"/> Chest Pains |
| <input type="checkbox"/> | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> | <input type="checkbox"/> Heart Pacemaker |

- Light Bothers Eyes Heart Problems

Other _____

1. List any medications you are taking:

2. Please list all doctors you are currently seeing:

3. Has any Doctor or other professional advised you to "Go to a Chiropractor ":

No Yes

Name _____

PAST HISTORY

4. List any past auto collisions: _____

Was any care received? _____

5. List any past work injuries: _____

Was any care received? _____

6. List any past sport, recreational, or home injuries

7. Please describe any past conditions and treatment received:

8. Please list any past hospitalizations and surgeries:

FAMILY HISTORY

Father's side: heart disease Cancer Diabetes Heavy Medication use

Arthritis Other _____

Mother's side: heart disease Cancer Diabetes Heavy Medication use

Arthritis Other _____

Is there any other family history you want us to know?
