Barneveld Family Chiropractic
HEALTH HISTORY FORM

Name: _____ Date: _____ _____

Family Physician: _____ Clinic:_____

Clinic Phone #:(_____)_____ Date of last physical exam:_____

Sex: M F Height: _____Weight: _____ Age:_____ # of Children: _____

✔ **Check the following conditions you have or have had. - ○ Circle items that are common to family members.**

GENERAL
- ☐ Alcoholism
- ☐ Allergy
- ☐ Anemia
- ☐ Appendicitis
- ☐ Cancer
- ☐ Convulsions
- ☐ Diabetes
- ☐ Dizziness or Fainting
- ☐ Headache
- ☐ Multiple Sclerosis
- ☐ Nerve Problems
- ☐ Numbness
- ☐ Polio
- ☐ Rheumatic Fever
- ☐ Stroke
- ☐ Tuberculosis

MUSCLE & JOINT
- ☐ Arthritis
- ☐ Foot trouble
- ☐ Gout
- ☐ Low back pain
- ☐ Neck pain or stiffness
- ☐ Pain between shoulders
- ☐ Sciatica
- ☐ Swollen joints

Pain/Numbness

- ☐ Shoulders ☐ Hips
- ☐ Arms ☐ Legs
- ☐ Elbow ☐ Knees
- ☐ Hands ☐ Feet

GASTRO-INTESTIONAL
- ☐ Colon Trouble
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficult Digestion
- ☐ Distension of abdomen
- ☐ Gall bladder trouble
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Liver trouble
- ☐ Pain over stomach
- ☐ Ulcers

EYES, EARS, NOSE & THROAT
- ☐ Asthma
- ☐ Colds
- ☐ Deafness
- ☐ Ear discharge
- ☐ Ear noises/ ringing
- ☐ Eye conditions/infections
- ☐ Goiter
- ☐ Nasal obstruction
- ☐ Nosebleeds
- ☐ Sinus infections
- ☐ Thyroid issues

HABITS: (Patient Only)
- ☐ Alcohol
- ☐ Coffee
- ☐ Drugs
- ☐ Medications
- ☐ Tobacco
- ☐ Vitamins

CARDIO-VASCULAR
- ☐ Chest pain
- ☐ Hardening of the arteries
- ☐ Heart disease
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Slow heartbeat
- ☐ Swelling of the ankles
- ☐ Varicose veins

RESPIRATORY
- ☐ Chest pain
- ☐ Chronic cough
- ☐ Difficulty breathing
- ☐ Emphysema
- ☐ Spitting up blood
- ☐ Spitting up phlegm

HAVE YOU EVER: (Patient Only)
- ☐ Had previous Chiropractic care
- ☐ Been knocked unconscious
- ☐ Used a crutch or other support
- ☐ Been treated for a spine or nerve disorder
- ☐ Had a fractured bone
- ☐ Been hospitalized for an event other than surgery
- ☐ Ever has a surgery (please list): _____

_____

_____

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SKIN
- ☐ Bruises
- ☐ Dryness
- ☐ Eczema
- ☐ Skin eruptions/ rash

GENITO-URINARY
- ☐ Bed-wetting
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Hot Flashes
- ☐ Inability to control bladder
- ☐ Kidney infections or stones
- ☐ Menstrual irregularities
- ☐ Menstrual pain
- ☐ Miscarriage
- ☐ Painful urination