



LifeArts – Howard Chiropractic, PC  
 110 South 6<sup>th</sup> Street  
 Plattsmouth, NE 68048  
 402-296-2196 lifearts.8k.com

Name: \_\_\_\_\_

Date: \_\_\_\_\_

### Health History Questionnaire

Reason for this visit: \_\_\_\_\_

Have you had this problem in the past?  yes  no Explain: \_\_\_\_\_

When did the symptoms begin? \_\_\_\_\_

Is it getting worse?  yes  no Is it constant?  yes  no

Describe the pain: \_\_\_\_\_

Does it interfere with:  work  school  sleep  daily routine  recreation

Is it painful to:  sit  walk  bend  lie down  lift objects

Have you been treated for this problem before?  yes  no If yes, by whom? \_\_\_\_\_

What was recommended? \_\_\_\_\_

What other health care professionals have you seen?  Medical Doctor  Doctor of Chiropractic

Physical Therapist  Osteopath  Massage Therapist  Acupuncturist

What activities do you typically do during the day? \_\_\_\_\_

Is this condition affecting your ability to perform these activities?  yes  no

Please explain: \_\_\_\_\_

Have you received chiropractic care in the past?  yes  no When? \_\_\_\_\_

Name of Chiropractor: \_\_\_\_\_ Reason for previous care: \_\_\_\_\_

Current Medical Doctor: \_\_\_\_\_

Do you .....

Exercise?  yes  no How many times per week? \_\_\_\_\_ What type of exercise? \_\_\_\_\_

Sleep well?  yes  no How many hours at a time? \_\_\_\_\_ Waterbed?  yes  no

Use any orthotics, shoe lifts, arch supports, etc.?  yes  no If yes, explain: \_\_\_\_\_

Smoke?  yes  no How much? \_\_\_\_\_ Drink alcohol?  yes  no How much? \_\_\_\_\_

Use caffeine?  yes  no How much? \_\_\_\_\_

Please fill in the following information:

Medication:	What is it for?	Who prescribed it?	List Allergies:	Surgeries:

Please check all conditions you currently have or have had in the past:

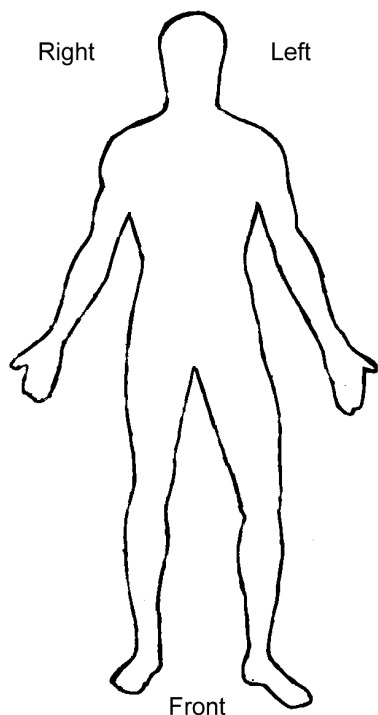
- |                                       |   |   |   |  |   |
|---------------------------------------|---|---|---|--|---|
| <input type="checkbox"/> HIV/AIDS     | <input type="checkbox"/> Alcoholism         | <input type="checkbox"/> Anemia               | <input type="checkbox"/> Anorexia / Bulimia | <input type="checkbox"/> Arthritis (where? _____)        |   |
| <input type="checkbox"/> Anxiety      | <input type="checkbox"/> Depression         | <input type="checkbox"/> ADD/ADHD             | <input type="checkbox"/> Breast lumps       | <input type="checkbox"/> Bronchitis                      | <input type="checkbox"/> Difficulty breathing |
| <input type="checkbox"/> Emphysema    | <input type="checkbox"/> Diabetes           | <input type="checkbox"/> Glaucoma             | <input type="checkbox"/> Cataracts          | <input type="checkbox"/> Cancer (where? _____)           |   |
| <input type="checkbox"/> Gout         | <input type="checkbox"/> Heart Disease      | <input type="checkbox"/> Hepatitis            | <input type="checkbox"/> Epilepsy           | <input type="checkbox"/> Fractures (where? _____)        |   |
| <input type="checkbox"/> Hernia       | <input type="checkbox"/> High cholesterol   | <input type="checkbox"/> Migraines            | <input type="checkbox"/> Headaches          | <input type="checkbox"/> Kidney disease                  | <input type="checkbox"/> Liver disease        |
| <input type="checkbox"/> Miscarriage  | <input type="checkbox"/> Multiple Sclerosis |   | <input type="checkbox"/> Osteoporosis       | <input type="checkbox"/> Pacemaker                       | <input type="checkbox"/> Pneumonia            |
| <input type="checkbox"/> Polio        | <input type="checkbox"/> Prostate Problems  |   | <input type="checkbox"/> Prosthesis         | <input type="checkbox"/> Psychiatric treatment           | <input type="checkbox"/> Scarlet fever        |
| <input type="checkbox"/> Stroke / TIA | <input type="checkbox"/> Suicide attempt    | <input type="checkbox"/> Rheumatoid Arthritis |   | <input type="checkbox"/> Rheumatic fever                 | <input type="checkbox"/> Thyroid problems     |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Tumors             | <input type="checkbox"/> Ulcers               | <input type="checkbox"/> Vaginal Infections | <input type="checkbox"/> Venereal disease (which? _____) |   |

Please check all symptoms that you currently have or have had in the past year:

- |  |   |  |   |   |
|--|---|--|---|---|
| <input type="checkbox"/> Chest pain / angina                   | <input type="checkbox"/> High blood pressure    | <input type="checkbox"/> Low blood pressure      | <input type="checkbox"/> Irregular heart beat | <input type="checkbox"/> Poor circulation   |
| <input type="checkbox"/> Ankle swelling                        | <input type="checkbox"/> Dizziness              | <input type="checkbox"/> Fainting                | <input type="checkbox"/> Bruise easily        | <input type="checkbox"/> Confusion          |
| <input type="checkbox"/> Memory problems                       | <input type="checkbox"/> Fatigue                | <input type="checkbox"/> Insomnia                | <input type="checkbox"/> Numbness             | <input type="checkbox"/> Nervousness        |
| <input type="checkbox"/> Unexplained weight loss / weight gain |   | <input type="checkbox"/> Fevers                  | <input type="checkbox"/> Vision changes       | <input type="checkbox"/> Troubles sleeping  |
| <input type="checkbox"/> Poor appetite                         | <input type="checkbox"/> Bowel changes          | <input type="checkbox"/> Constipation            | <input type="checkbox"/> Diarrhea             | <input type="checkbox"/> Bloating           |
| <input type="checkbox"/> Nausea / vomiting                     | <input type="checkbox"/> Excessive thirst       | <input type="checkbox"/> Excessive hunger        | <input type="checkbox"/> Hemorrhoids          | <input type="checkbox"/> Indigestion        |
| <input type="checkbox"/> Rectal bleeding                       | <input type="checkbox"/> Abdominal pain         | <input type="checkbox"/> Frequent urination      | <input type="checkbox"/> Inability to urinate | <input type="checkbox"/> Bladder infections |
| <input type="checkbox"/> Bloody urine                          | <input type="checkbox"/> Burning with urination | <input type="checkbox"/> Loss of bladder control | <input type="checkbox"/> Hives / rash         | <input type="checkbox"/> Itching            |
| <input type="checkbox"/> Changes in moles                      | <input type="checkbox"/> Non-healing sores      | <input type="checkbox"/> Difficulty swallowing   | <input type="checkbox"/> Earaches / discharge | <input type="checkbox"/> Nosebleeds         |
| <input type="checkbox"/> Hay fever / allergies                 | <input type="checkbox"/> Persistent cough       | <input type="checkbox"/> Ringing in ears         | <input type="checkbox"/> Sinus problems       | <input type="checkbox"/> Voice changes      |
| <input type="checkbox"/> Erectile dysfunction                  | <input type="checkbox"/> Lumps in testicles     | <input type="checkbox"/> Penile discharge        | <input type="checkbox"/> Abnormal pap smear   | <input type="checkbox"/> Vaginal discharge  |
| <input type="checkbox"/> Irregular menstrual cycles            | <input type="checkbox"/> Menstrual pain         | <input type="checkbox"/> Painful intercourse     | <input type="checkbox"/> Nipple discharge     |   |

Date of last menstrual period: \_\_\_\_\_ Date of last pap smear \_\_\_\_\_ Are you pregnant? \_\_\_\_\_

Have you had a mammogram? \_\_\_\_\_ Do you do self breast / testicular exams? \_\_\_\_\_



Please indicate on the diagram the area(s) of complaint using the key:

- P = pain
- N = numbness
- S = stiffness
- W = weakness
- M = muscle spasm

Feel free to add anything else that you feel would help describe your condition and areas of complaint.

