



LifeArts – Howard Chiropractic, PC

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 Plattsmouth, NE 68048
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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: |
|-------------|-----------------|--------------------|-----------------|------------|
| | | | | |
| | | | | |
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| | | | | |
| | | | | |

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

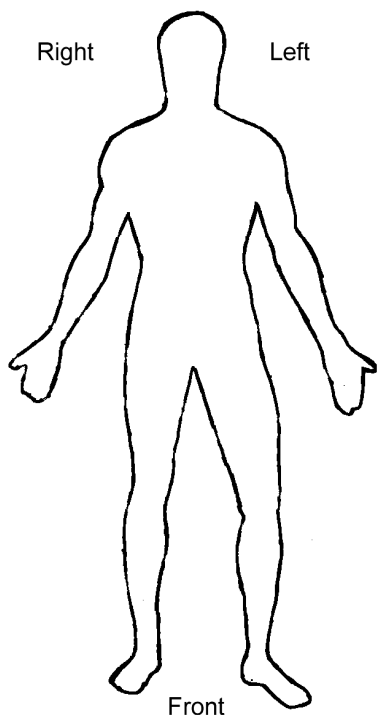
- | | | | | | |
|---------------------------------------|---|---|--|--|---|
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Anemia | <input type="checkbox"/> Anorexia / Bulimia | <input type="checkbox"/> Arthritis (where? _____) | |
| <input type="checkbox"/> 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.

