

GENERAL HEALTH HISTORY



126 N. Sibley Ave
Litchfield, MN 55355

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 |
| <input type="checkbox"/> | <input type="checkbox"/> Light Bothers Eyes | <input type="checkbox"/> | <input type="checkbox"/> Heart Problems |
| <input type="checkbox"/> | <input type="checkbox"/> Other _____ | | |

1. List any medications are you 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? _____