CENTER FOR HEALTH
DR. GARY J. POST, CHIROPRACTIC PHYSICIAN
24 SALT POND RD., SUITE C5
WAKEFIELD, RI O2879
401-789-5008 401-789-5550 FAX

GENERAL HEALTH HISTORY QUESTIONNAIRE

Name: _____ Today's Date: _____
Address: _____
Phone: Home: _____ Cell: _____Work: _____Email: _____
Social Security #: _____Sex: ☐M ☐F Date of Birth: _____ Marital Status: _____
Occupation: _____ Number of Children: _____
Patient's Employer/School: _____ Phone: _____
Employer/School Address:
_____
_____
Spouse's Name: _____ Birthdate: _____
Spouse's Employer: _____ Social Security #: _____
Best time and place to reach you? _____
Whom may we thank for referring you? _____

IN CASE OF EMERGENCY, CONTACT:
Name: _____ Relationship: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____

Place a mark indicating if you have had any of the following with a "Yes" or "No".

	Y	N		Y	N		Y	N		Y	N
AIDS/HIV			Diabetes			Liver Disease			Psychiatric Care		
Alcoholism			Emphysema			Measles			RheumatoidArthritis		
Anemia			Epilepsy			Migraine Headache			Rheumatic Fever		
Anorexia			Fractures			Miscarriage			Scarlet Fever		
Appendicitis			Glaucoma			Mononucleosis			Sexually Tran Dis		
Arthritis			Goiter			Multiple Sclerosis			Stroke		
Asthma			Gonorrhea			Mumps			Suicide Attempt		
Bleeding Disorders			Gout			Osteoporosis			Thyroid Problems		
Breast Lump			Heart Disease			Pacemaker			Tonsillitis		
Bronchitis			Hepatitis			Parkinsons Disease			Tuberculosis		
Bulimia			Hernia			Pinched Nerve			Tumors, Growths		
Cancer			Herpes			Pneumonia			Typhoid Fever		
Cataracts			High Blood Pressu			Polio			Ulcers		
Chemical Dependent			High Cholesterol			Prostate Problem			Vaginal Infection		
Chicken Pox			Kidney Disease			Liver Disease			Whooping Cough		

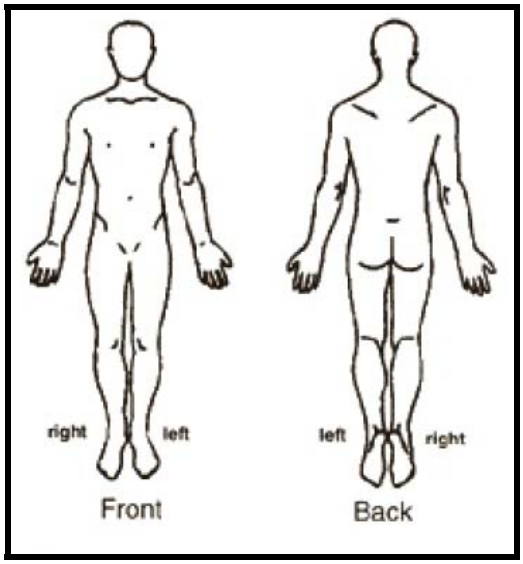
Date of last Physical Exam: _____ Date of last X-Ray/CT Scan/MRI _____
Have you been to a chiropractor before? ☐ Yes ☐No If so, when? _____

REASONS FOR VISIT

Main Chief Complaint: (1) _____
Other Chief Complaints: (2) _____
(3) _____

When did you symptoms first appear? _____
Is your condition getting worse? ☐Yes ☐No ☐Constant ☐Comes and goes

Mark an X on the picture at the sites where you continue to have pain, tingling, or numbness.
Rate the severity of the pain at each site on a scale of 1 (least pain) through 10 (most pain).



Type of pain:

☐Sharp ☐Dull ☐Throbbing ☐Numbness ☐Aching ☐Shooting
☐Burning ☐Tingling ☐Cramping ☐Stiffness ☐Swelling ☐Other_____

How often do you have this pain? ☐Constantly ☐Most of the time ☐Daily ☐Several times per week ☐Other
If other, explain: _____
Does it interfere with your? ☐Work ☐Sleep ☐Recreation ☐Daily Routine ☐Other _____
Activities or motions that are painful: ☐Sitting ☐Standing ☐Lifting ☐Bending ☐Walking ☐Lying down
What treatment have you already received for your condition?
☐Medication ☐Surgery ☐Physical Therapy ☐Chiropractic ☐None ☐Other _____
Name and address of other doctor(s) who have treated you for your condition:
_____

DAILY LIVING

Exercise: ☐None ☐Moderate ☐Daily ☐Heavy
Work Activity: ☐Sitting ☐Standing ☐Light labor ☐Heavy Labor
Habits: ☐Smoking: Packs/Day _____ ☐Alcohol: Drinks/Week ____ ☐Coffee/Caffeine: Cups/Day _____
☐High Stress Level Reason _____
Medications Currently Taking: _____
Operations:_____
Allergies _____ Are you pregnant? ☐ Yes ☐No Due Date: _____
Vitamins/Herbs/Minerals you are currently taking: _____