**CENTER FOR HEALTH**
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# 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 | | |
| | | | | | | | | | | | |

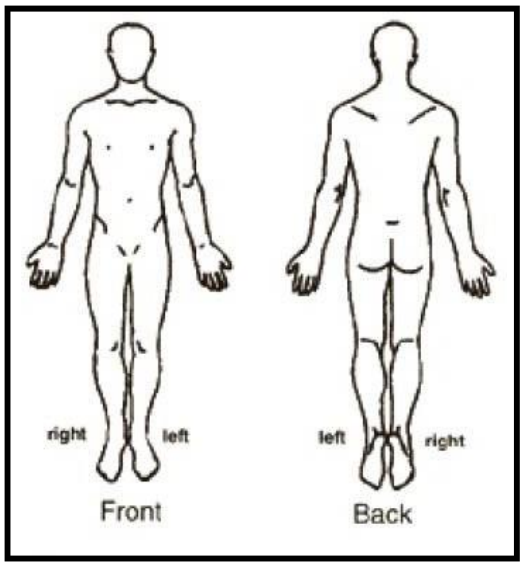
Date of last Physical Exam:_____Date of last X-Ray/CT Scan/MRI _____
Have you been to a chiropractor before? ☐ Yes ☐No If so, when? _____

## 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:

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## 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: _____