LARGE CHIROPRACTIC CLINIC Dr. Todd H. Large

**PAST HEALTH HISTORY FORM**

The following may seem unrelated to the purpose of your appointment; however, these questions must be answered carefully as these problems can affect your overall course of chiropractic care.

**PLEASE CHECK ALL THAT APPLY**

**MAJOR SURGERIES/OPERATIONS:**

- o Appendectomy
- o Broken Bones
- o Back Surgery
- o Gall Bladder
- o Hernia
- o Tonsillectomy
- o Other: _____

**MAJOR ACCIDENT OR FALLS (OTHER THAN WHAT YOU ARE BEING SEEN FOR TODAY)**

_____

_____

**HOSPITALIZATION (OTHER THAN ABOVE)** _____

_____

**PLEASE LIST ALL PRESCRIPTION AND OVER-THE-COUNTER MEDICATIONS YOU ARE CURRENTLY TAKING:**

_____

_____

**DO YOU WEAR A SHOE LIFT?** () Yes () No

**CHECK ANY OF THE FOLLOWING DISEASE YOU HAVE HAD:**

- o Pneumonia
- o Anemia
- o Diabetes
- o Pleurisy
- o Rheumatic Fever
- o Measles
- o Cancer
- o Arthritis
- o Polio
- o Mumps
- o Heart Disease
- o Epilepsy
- o Tuberculosis
- o Small Pox
- o Thyroid
- o Mental Disorders
- o Whooping Cough
- o Chicken Pox
- o Influenza
- o Lumbago
- o Eczema

Intake

- o Coffee, Cups/Day__
- o Tea, Cups/Day____
- o Alcohol, Drks/Wk__
- o Cigarettes, Pk/Day_
- o White Sugar

**CHECK ANY OF THE FOLLOWING YOU HAVE HAD REGULARLY THE PAST 6 MONTHS:**

**MUSCULO-SKELETAL**

- o Low Back Pain
- o Pain Between Shoulders
- o Neck Pain
- o Arm Pain
- o Joint Pain/stiffness
- o Walking Problems
- o Difficult Chewing/Clicking Jaw
- o General Stiffness

**EENT**

- o Vision Problems
- o Dental Problems
- o Sore Throat
- o Ear Aches
- o Hearing Difficulty
- o Stuffed Nose

**GASTRO-INTESTINAL**

- o Poor/Excessive Appetite
- o Excessive Thirst
- o Frequent Nausea
- o Vomiting
- o Diarrhea
- o Constipation
- o Hemorrhoids
- o Colitis
- o Liver Problems
- o Gall Bladder Problems
- o Weight Trouble
- o Abdominal Cramps
- o Gas/Bloating After Meals
- o Heartburn
- o Black/Blood Stool

**C-V-R**

- o Chest Pain
- o Short Breath
- o Blood Pressure Problems
- o Irregular Heart Beat
- o Heart Problems
- o Lung Problems/Congestion
- o Varicose Veins
- o Ankle Swelling
- o Stroke

**MALE/FEMALE**

- o Menstrual Irregularity
- o Menstrual Cramps
- o Vaginal Pain/Infection
- o Breast Pain/Lumps
- o Prostate/Sexual Dysfunction
- o Other Problems: ____

**NERVOUS SYSTEM**

- o Nervousness
- o Numbness
- o Stress
- o Paralysis
- o Dizziness
- o Forgetfulness
- o Confusion
- o Depression
- o Fainting
- o Convulsions
- o Cold/Tinging Extremities

**FEMALES ONLY:**

When Was Your Last Period? _____

Are You Pregnant?

- o Yes
- o No

Not Sure

**GENITO-URINARY**

- o Bladder Trouble
- o Painful/Excessive Urination
- o Discolored Urine

**GENERAL**

- o Fatigue
- o Allergies
- o Loss of Sleep
- o Fever
- o Headaches

**FAMILY HISTORY**

The following members have a same or similar problem as I do:

- o Parent
- o Sibling
- o Spouse
- o Child

**Patient/Parent-Guardian Signature: _____** **Today's Date: _____/_____/_____**