ARCTIC CHIROPRACTIC NOME

Health History

Please answer all to the best of your ability.

Have you been treated by a physician for any health condition in the last year? Yes No

If yes, what was treatment for? _____ Date of Last Physical Exam _____/_____/_____

Are you currently taking any medication? Yes No If yes, what medications? _____

Are you allergic to any medication? Yes No If yes, what medications? _____

FEMALE ONLY: Are you pregnant? Yes No Date of Last Menstrual Period? _____/_____/_____

Has a medical doctor every told you not to be treated by a chiropractor for a specific condition? Yes No

If yes, what condition? _____

Please Check Major Surgeries/Operations:

☐ Appendectomy ☐Tonsillectomy ☐Gall Bladder ☐Hernia ☐Back Surgery ☐Heart

Other_____

HAVE YOU EVER BEEN DIAGNOSED WITH OR EVER BEEN TOLD YOU HAD ANY OF THE FOLLOWING:

☐ High Blood Pressure	☐ Were you ever a smoker?	☐ Slurred Speech/Dizziness
☐ Hardening of the Arteries	☐ Visual Disturbances	☐ Difficulty Swallowing
☐ Diabetes	☐ Hearing Disturbances	☐ Arthritis
☐ Tuberculosis	Diabetes Type ☐I ☐ II	☐ Loss of Consciousness
☐ Osteoporosis	☐ Cancer	☐ Numbess or loss of sensation
☐ Bone Spurs	☐ Heart/Blood Disease	☐ Stroke/VBAI
☐ Whiplash Injury	☐ Thyroid	☐ Sudden Collapse

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

NERVOUS SYSTEM	**MUSCULO-SKELETAL**	**C-V-R**
☐ Nervous	☐ Low Back Pain	☐ Chest Pain
☐ Numbness	☐ Pain Between Shoulders	☐ Short Breath
☐ Paralysis	☐ Neck Pain	☐ Blood Pressure Problems
☐ Dizziness	☐ Arm Pain R L Both	☐ Irregular Heartbeat
☐ Forgetfulness	☐ Joint Pain/Stiffness	☐ Pacemaker
☐ Confusion/Depression	☐ Walking Problems	☐ Lung Problems
☐ Fainting	☐ Difficult Chewing/Clicking Jaw	☐ Varicose Veins
☐ Convulsions	☐ General Stiffness	☐ Ankle Swelling
☐ Cold/Tingling Extremities	☐ Hip Pain R L Both	☐ Stroke
☐ Stress	☐ Leg Pain R L Both	
	☐ Knee Pain R L Both	**EENT**
GENERAL		☐ Vision Problems
☐ Poor/Excessive Appetite	**GENITO-URINARY**	☐ Dental Problems
☐ Excessive Thirst	☐ Bladder Trouble	☐ Sore Throat

ARCTIC CHIROPRACTIC NOME

Health History (Continued)

GENERAL (Cont)	GASTRO-INTESTINAL (Cont)	EENT (Cont)
☐ Diarrhea	☐ Heartburn	☐ Stuffed Nose/Sinus Problems
☐ Vomiting	☐ Discolored Urine	☐ Hearing Difficulty
☐ Frequent Nausea	☐ Black/Bloody Stool	☐ Ear Aches/Ringing in Ears
	☐ Painful/Excessive Urination	
GASTRO-INTESTINAL	☐ Pain in the Bowel	**Women's Health Only**
☐ Poor/Excessive Appetite		☐ Painful Menstruation
☐ Excessive Thirst	**RESPIRATORY**	☐ Hot Flashes
☐ Frequent Nausea	☐ Chronic Cough	☐ Cramps or Back Pain
☐ Vomiting	☐ Spitting up Plegm	☐ Vaginal Discharge
☐ Diarrhea	☐ Spitting up Blood	☐ Lumps in Breast
☐ Constipation	☐ Chest Pain	☐ Miscarriages
☐ Hemorrhoids	☐ Wheezing	☐ Complications with Pregnancy
☐ Liver Problems	☐ Difficulty Breathing	
☐ Gall Bladder Problems	☐ Asthma	**Men's Health Only**
☐ Weight: Loss Gain		☐ Prostrate Problems
☐ Abdominal Cramps		☐ Testicular Pain
☐ Gas/Bloating After Meals		☐ Low Back Pain

Is there anything else we should know about your health history? Y N Please Describe Below

_____ _____

PATIENT (PARENT/GUARDIAN) SIGNATURE DATE

Office Use Only:

Treatment provided _____ Y _____ N

No Treatment Provided _____ Y _____ N

Insurance Billed: _____ Y _____ N