PATIENT HEALTH HISTORY (MVA)

Patient's Name _____ **Today's Date** _____

Your Health History (circle "**C**" if the problem is a current one and "**P**" if you've only had it in the past)

General	Muscles & Joints	Eyes, Ears, Nose & Throat	Gastrointestinal
C P Anemia	C P Arthritis	C P Hearing Loss	C P Colon Problems
C P Allergy shots	C P Bursitis	C P Ear-ache / pain	C P Constipation
C P Convulsions	C P Neck Pain/Stiffness	C P Cataracts / Glaucoma	C P Diarrhea
C P Dizziness	C P Shoulder Pain	C P Failing Vision	C P Gall Bladder
C P Fainting	C P Mid-back Pain	C P Nosebleeds	C P Hemorrhoids
C P Fatigue	C P Low Back Pain/Stiff	C P Sinus Infections	C P Hernia
C P Headaches	C P Spinal Curvature	C P Strep Throat	C P Liver Problems
C P Migraines	C P Herniated Disc	C P Thyroid Problems	C P Nausea / Vomiting
C P Sudden Weight Loss	C P Osteoporosis	C P Goiter	C P Poor Digestion

Respiratory	Pain or Numbness in:	Skin Problems	Other
C P Asthma	C P Head / Face	C P Acne	C P Cancer / Malignancy
C P Bronchitis	C P Shoulders / Arms	C P Bleeding Disorders	C P Diabetes
C P Chest Pain	C P Elbows / Hands	C P Bruise Easily	C P Chemical Dependency
C P Chronic Cough	C P Fingers / Toes	C P Hives or Allergic Reaction	C P Chicken Pox
C P Emphysema	C P Hips / Legs	C P Skin Rash	C P Measles
C P Spitting up Blood	C P Ankles/Knees/Feet	C P Surface Scars	C P Mononucleosis
C P Pneumonia or TB	C P Prosthesis	C P Deep Scars	C P Mumps
			C P Polio
Cardio-Vascular	**Genito-Urinary**	**Neurological**	C P Rheumatic Fever
C P Heart Disease	C P Bedwetting	C P Alcoholism	C P Scarlet Fever
C P High B/P	C P Frequent Urination	C P Alzheimer's	C P Typhoid Fever
C P Low B/P	C P Painful Urination	C P Epilepsy	C P Whooping Cough
C P Rapid Heart Beat	C P Gout	C P Parkinson's	C P Multiple Sclerosis
C P Slow Heart Beat	C P Kidney Infection	C P Seizures	C P Sexual Transmitted Disease
C P Arrhythmia	C P Kidney Stones	C P Stroke	C P HIV Positive
C P High Cholesterol	C P Prostate Trouble	C P Trouble Sleeping	C P Psychiatric Care
C P Pacemaker	C P Swelling of Ankles	C P Unable to Relax	C P Tumors / Growths

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For Women Only		
C P Cramps or Backache w/cycle	C P Pain with intercourse	C P Facial Hair / Thinning Hair
C P Irregular Cycle Length	C P Unable to Conceive	C P Breast Implants
C P Scanty or Excess Flow	C P Miscarriage(s)	C P Hysterectomy
C P Breast or Ovarian Cysts	C P Pelvic Inflammatory Disease	C P Use of the "Pill" or IUD
	C P PMS / Painful Menstruation	C P Menopausal

Are you pregnant at this time? ❒ Yes ❒ No ❒ Possibly Date last cycle started _____

Your Family History (some health problems result from familial tendencies)

Family Member	Illnesses	Current Age (or) age at death	Cause of Death or N/A
Mother	_____	_____	_____
Father	_____	_____	_____
Sister(s)	_____	_____	_____
Brother(s)	_____	_____	_____

Marital Status: ❒ Single ❒ Married ❒ Widowed ❒ Sep ❒ Div Ages of Children ____, ____, ____, ____

Current medications (including non-prescription):

Name of Medication	Reason for taking it	When you began taking it
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Previous prescribed medications:

Name of Medication	Reason for taking it	How long you took it
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Past Injuries and Surgeries: Description and Dates of Occurrence Age at time

Sports / Work / Auto Accidents _____ _____
Falls _____ _____
Head Injuries _____ _____
Fractures / Dislocations _____ _____
Surgeries _____ _____

Current Occupation _____ **Employer** _____

❒ Full Time ❒ Part Time Hours/wk_____ Normal work hours: from _____ to _____
How long how you been with this employer?_____ How long have you been doing this type of work? _____
Describe your normal job duties: _____
_____

Previous Jobs of Any Length:

Job Title	Main Duties	Dates Doing That Work
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Activities and Lifestyle:

Work activity: ❒ Mainly Sitting ❒ Mainly Standing/Walking ❒ Light Labor ❒ Heavy Labor _____
Regular exercise: ❒ None ❒ Light ❒ Moderate ❒ Heavy ❒ ___ times weekly
Coffee/Caffeine consumption: ❒ Never ❒ Not for ___years ❒ ___cups per day
Alcohol consumption: ❒ Never ❒ Not for ___years ❒ ___drinks per day/week
Tobacco consumption: ❒ Never ❒ Not for ___years ❒ ___packs per day For how long?_____
Do you consume just water? ❒ Yes ❒ No ___glasses/day How many bowel movements each day? _____
Are you on any particular diet? ❒ Yes ❒ No Describe _____
What vitamins/minerals/herbs do you take? _____

List any known allergies / sensitivities _____

Have you had chiropractic care before? ❒ Yes ❒ No If yes, was your experience: ❒ Good ❒ Fair ❒ Poor
Duration of care _____ Frequency of care _____ Preferred style? ❒ Manipulation ❒ Low force