Advanced Chiropractic and Nutrition
54 The Legends Parkway, Ste. 154
Eureka, MO 63025
636-938-1010

PATIENT HEALTH HISTORY - Chiropractic

Please complete this questionnaire. Your answers will help us determine how Chiropractic can help you.

NAME____ **INITIAL VISIT DATE** _________________

How did you hear about our clinic? ❑Y Pgs ❑Internet ❑Referral _____________ ❑Other______________

Have you had Chiropractic care before? ❑Yes ❑No Dr.__________________ Last Visit: _______________

Have you ever had **"Spinal" X-rays taken?** ❑Yes ❑No Reason: _________________ Date: ___________

Other "Diagnostic Imaging": ❑MRI ❑CT ❑Ultrasound ❑Other Date:___________ Location:_____________

Please circle ( ) present conditions and check (✔) previous conditions.

GENERAL SYMPTOMS
HEADACHES
MIGRAINES
FEVER
CHILLS
SWEATS
FAINTING
DIZZINESS
SEIZURES
CONVULSIONS
LOSS OF SLEEP
FATIGUE
NERVOUSNESS
LOSS OF WEIGHT
NUMBNESS OR TINGLING IN ARMS, LEGS OR HANDS
ALLERGIES
WHEEZING

E.E.N.T.
FAILING VISION
NEAR SIGHTED
FAR SIGHTED
EYE PAIN
HEARING LOSS
EARACHE
RINGING IN EARS
NOSEBLEEDS
SORE THROAT
HOARSENESS
ASTHMA
CHRONIC COUGH
FREQUENT COLDS
ENLARGED THRYROID
TONSILITIS
SINUS INFECTION
ENLARGED GLANDS

SKIN
ITCHING
RASHES
BRUISING EASILY
VARICOSE VEINS
SENSITIVE SKIN
HIVES

RESPIRATORY
CHRONIC COUGH
SPITTING UP PHLEGM
CHEST PAIN WITH BREATHING
DIFFICULT BREATHING

CARDIOVASCULAR
RAPID HEART BEAT
SLOW HEART BEAT
HIGH BLOOD PRESSURE
LOW BLOOD PRESSURE
CHEST PAIN ON ACTIVITY
PREVIOUS STROKE
HARDENING OF ARTERIES
SWOLLEN ANKLES
POOR CIRCULATION

MUSCLE & JOINT
NECK ACHE
BACKACHE
SWOLLEN JOINTS
PAINFUL TAILBONE
FOOT PAIN
SHOULDER PAIN
KNEE PAIN
HERNIA
SPINAL CURVATURE
FAULTY POSTURE
ARTHRITIS

GENITOURINARY
FREQUENT URINATION
PAINFUL URINATION
BLOOD IN URINE
KIDNEY INFECTION
KIDNEY STONES
BED WETTING
BLADDER INCONTINANCE
PROSTATE TROUBLE

GASTROINTESTINAL
POOR APPETITE
DIFFICULT DIGESTION
EXCESSIVE HUNGER
BELCHING
HEARTBURN
NAUSEA
VOMITING
STOMACH PAIN
CONSTIPATION
DIARRHEA
FLATULENCE
HEMORRHOIDS
LIVER TROUBLE
GALL BLADDER TROUBLE
JAUNDICE
COLITIS

WOMEN ONLY
PAINFUL MENSTRUATION
EXCESSIVE FLOW
HOT FLASHES
IRREGULAR CYCLE
CRAMPS OR BACKACHE
CONGESTED BREAST
LUMPS IN BREAST

Have you ever had any of the following diseases/conditions?

HYPERTENSION	MUMPS	EPILEPSY	CHICKEN POX	DIPTHERIA	OSTEOARTHRITIS
HEART DISEASE	MEASLES	DIABETES	SHINGLES	POLIO	RHEUMATOID ARTHRITIS
LUNG DISEASE	RUBELLA	ANEMIA	MONONUCLEOSIS	INFLUENZA	GOUT
CANCER	MALARIA	HYPERTHYROIDISM	VENEREAL DISEASE	SCARLET FEVER	PSORIASIS
STROKE	TUBERCULOSIS	HYPOTHYROIDISM	ALCOHOLISM	RHEUMATIC FEVER	SCOLIOSIS

Other (specify):____

Has anyone in your family had any of the following conditions/diseases?

HYPERTENSION	DIABETES	SCOLIOSIS	LOW BACK PAIN
HEART DISEASE	TUBERCULOSIS	RHEUMATOID ARTHRITIS	DISC DISEASE
LUNG DISEASE	MULTIPLE SCLEROSIS	ANKYLOSING SPONDYLITIS	SPINAL SURGERY
STROKE	ALZHEIMERS DISEASE	OSTEOARTHRITIS	MIGRAINE HEADACHES
CANCER	GOUT	OSTEOPOROSIS	EPILEPSY

Other (specify): ____

Smoking: ❑Yes ❑No How long? ________________ **Pregnancy**: ❑Yes ❑No How many weeks? ___________

Medications/Supplements you currently take:____

Surgeries you have had in the past: ____