SCHMITZ CHIROPRACTIC
Family Wellness Center

Health History

Patients Name:_____
Please fill in the blank or circle all that apply:

Have you been to a Chiropractor before? YES NO
Reason for Visit_____
Is this due to an auto accident or work related injury? YES NO
If YES, who have you notified? Employer, Auto Insurance, Lawyer, other_____
When did your symptoms begin?_____
Possible cause of symptoms?_____
Have you had similar symptoms in the past? YES NO
What increases symptoms? Standing, sitting, lying, lifting, bending, other_____
What decreases symptoms? Ice, heat, massage, rest, sitting, standing, medication, other_____
Please describe your symptoms: dull ache, sharp, shooting, burning, numbness, tingling, other_____
Do your symptoms radiate to other areas? (down the arms or legs) YES NO
_____
Are your symptoms: getting better, getting worse, staying the same.
Have you seen any other health care providers for this condition? YES NO
_____
Indicate the intensity of pain NONE 1 2 3 4 5 6 7 8 9 10 UNBEARABLE
Please list any uncommon or severe childhood or adult illnesses:
_____
Please list any serious injuries, operations, fractures, etc._____
_____
Have you ever been in an auto accident or work related injury? YES NO
Do you have any allergies?_____
Do you exercise? YES NO How many times per week?_____
Do you take any medication? (prescription or over the counter)_____
_____

Work activity: Sitting, standing, light labor, moderate labor, heavy labor, other_____

Habits: Do you and how much?

Smoke_____alcohol_____ coffee_____

How would you rate your overall health? Excellent, good, fair, poor.

FEMALE – Are you pregnant? YES NO

Is there a family history of disease? YES NO _____

_____

Circle all that apply:

AIDS/HIV	Cataracts	Hepatitis	Mumps
Alcoholism	Chemical Dependency	Hernia	Osteoporosis
Anemia	Chicken Pox	Herniated Disc	Pacemaker
Anorexia	Diabetes	Herpes	Parkinson's
Appendicitis	Emphysema	High Cholesterol	Pinched Nerve
Arthritis	Epilepsy	High Blood Pressure	Pneumonia
Asthma	Fractures	Kidney Disease	Polio
Bleeding Disorders	Glaucoma	Liver Disease	Prostate
Breast Lumps	Goiter	Rheumatic Fever	Measles
Bronchitis	Gonorrhea	Migraine Headaches	Scarlet Fever
Bulimia	Gout	Miscarriage	Stroke
Cancer	Heart Disease	Multiple Sclerosis	Tonsillitis
Tuberculosis	Tumors/Growths	Typhoid Fever	Ulcers
Venereal Disease	Whooping Cough	Rheumatoid Arthritis	

I certify that the above information is correct to the best of my knowledge. I will not hold Schmitz Chiropractic responsible for any errors or omissions that I may have made while completing this form. I understand that Chiropractic is not a treatment or a cure for any disease.

PATIENT SIGNATURE:_____DATE:_____

GUARDIAN SIGNATURE:_____DATE:_____