



Health History

Patient Name and Date: _____

Your Habits: Smoking Packs/Day: _____ Alcohol Drinks/Week _____ Caffeine Cups/Day: _____

How Much Do You Exercise? None Light Activity Moderate Activity Active Very Active Elite Athlete

Family History

	Diabetes	Heart	Kidney	Cancer	Other
Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brother, # of _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sister, # of _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Have You Had, or Do You Have Any of the Following Conditions?

- | | | | | |
|---|--|---|--|------------------------------------|
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Goiter | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Influenza | <input type="checkbox"/> Mental Disorder | <input type="checkbox"/> Polio | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Pleurisy |
| <input type="checkbox"/> Lumbago | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Cancer | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Herpes | <input type="checkbox"/> Multiple Sclerosis | | |

Please check a box for each condition listed below you have either experienced in the past or presently.

	Past	Present		Past	Present		Past	Present
General Symptoms			Gastro-Intestinal			Eye/Ear/Nose/Throat		
Allergy: (to what) _____	<input type="checkbox"/>	<input type="checkbox"/>	Belching/Gas/Bloating	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>	Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>
Chills	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Deafness	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Earache	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Eating	<input type="checkbox"/>	<input type="checkbox"/>	Ear Discharge	<input type="checkbox"/>	<input type="checkbox"/>
Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Gall Bladder Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Ear Noises	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	Enlarged Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
Fever	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Colds	<input type="checkbox"/>	<input type="checkbox"/>
Headache	<input type="checkbox"/>	<input type="checkbox"/>	Liver Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Sleep	<input type="checkbox"/>	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	<input type="checkbox"/>	Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Weight	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Pain	<input type="checkbox"/>	<input type="checkbox"/>	Nosebleeds	<input type="checkbox"/>	<input type="checkbox"/>
Nervousness	<input type="checkbox"/>	<input type="checkbox"/>	Poor Appetite	<input type="checkbox"/>	<input type="checkbox"/>	Pain in Eyes	<input type="checkbox"/>	<input type="checkbox"/>
Neuralgia	<input type="checkbox"/>	<input type="checkbox"/>	Poor Digestion	<input type="checkbox"/>	<input type="checkbox"/>	Poor Vision	<input type="checkbox"/>	<input type="checkbox"/>
Sweats	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	Sinusitis	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting Blood	<input type="checkbox"/>	<input type="checkbox"/>	Sore Throat	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Thirst	<input type="checkbox"/>	<input type="checkbox"/>	Tonsillitis	<input type="checkbox"/>	<input type="checkbox"/>
Muscles/Joints/Bones			Indigestion	<input type="checkbox"/>	<input type="checkbox"/>	Persistent Cough	<input type="checkbox"/>	<input type="checkbox"/>
Backache	<input type="checkbox"/>	<input type="checkbox"/>	Rectal Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Swallowing	<input type="checkbox"/>	<input type="checkbox"/>
Foot Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Cardio-Vascular			Bleeding Gums	<input type="checkbox"/>	<input type="checkbox"/>
Hernia	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Skin		
Pain in Shoulders	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Boils	<input type="checkbox"/>	<input type="checkbox"/>
Painful Tail Bone	<input type="checkbox"/>	<input type="checkbox"/>	Pain Over Heart	<input type="checkbox"/>	<input type="checkbox"/>	Bruising Easily	<input type="checkbox"/>	<input type="checkbox"/>
Stiff Neck	<input type="checkbox"/>	<input type="checkbox"/>	Poor Circulation	<input type="checkbox"/>	<input type="checkbox"/>	Dryness	<input type="checkbox"/>	<input type="checkbox"/>
Spinal Curvature	<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Eczema	<input type="checkbox"/>	<input type="checkbox"/>
Swollen Joints	<input type="checkbox"/>	<input type="checkbox"/>	Rapid Heart	<input type="checkbox"/>	<input type="checkbox"/>	Itching	<input type="checkbox"/>	<input type="checkbox"/>
Tremors/Twitching	<input type="checkbox"/>	<input type="checkbox"/>	Slow Heart	<input type="checkbox"/>	<input type="checkbox"/>	Sensitive Skin	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory			Strokes	<input type="checkbox"/>	<input type="checkbox"/>	Skin Eruptions	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Genito-Urinary			For Women Only		
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	Bed Wetting	<input type="checkbox"/>	<input type="checkbox"/>	Cramps/Backaches	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty	<input type="checkbox"/>	<input type="checkbox"/>	Blood in Urine	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Flow	<input type="checkbox"/>	<input type="checkbox"/>
Spitting Blood	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Urination	<input type="checkbox"/>	<input type="checkbox"/>	Hot Flashes	<input type="checkbox"/>	<input type="checkbox"/>
Spitting Phlegm	<input type="checkbox"/>	<input type="checkbox"/>	Lack of Bladder Control	<input type="checkbox"/>	<input type="checkbox"/>	Irregular Cycle	<input type="checkbox"/>	<input type="checkbox"/>
			Kidney Infection	<input type="checkbox"/>	<input type="checkbox"/>	Miscarriage	<input type="checkbox"/>	<input type="checkbox"/>
			Painful Urination	<input type="checkbox"/>	<input type="checkbox"/>	Vaginal Discharge	<input type="checkbox"/>	<input type="checkbox"/>



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Lump in Breast

Pregnant at this time? Yes No

Health History – Page 2

Patient Name and Date _____

Please list any operations/surgeries you have had and the date of procedures: _____

Please list any accidents/falls and the dates: Car: _____
 Recreation/Sports: _____ Other: _____

List any fractures or dislocations: _____

Have you ever had X-rays taken? Yes No When and for what ailment? _____

Have you ever had any spinal taps or spinal injections? Yes No

Were you ever knocked unconscious? Yes No

Have you ever had a lapse of memory? Yes No

Do you suffer from any condition other than that for which you are here? _____

Please list any medication – prescription or over-the-counter – that you are currently taking: _____
