CAROLINALIFE Chiropractic

GENERAL HEALTH HISTORY

Confidential

2700 Woodruff Rd. L. Simpsonville, SC 29681

Patient Name_____ *Mark the conditions that apply to you.*

Past	Present		Past	Present	
❑	❑	Joint Pain / Arthritis	❑	❑	Digestive Problems
❑	❑	TMJ or Extremity Pain	❑	❑	Chron's / IBS / UC
❑	❑	Headaches/Migraines	❑	❑	Liver Disease
❑	❑	Stroke History	❑	❑	Kidney Problems
❑	❑	Concentration Problems	❑	❑	Urinary Problems
❑	❑	Anxiety / Depression	❑	❑	Thyroid Problems
❑	❑	Tension / Irritability	❑	❑	Diabetes
❑	❑	Dizziness / Nausea	❑	❑	Obesity / Overweight
❑	❑	Vertigo	❑	❑	Fibromyalgia
❑	❑	Sinus/Nasal Trouble	❑	❑	Multiple Sclerosis
❑	❑	Earache / Problems	❑	❑	Autoimmune disease
❑	❑	Vision Problems	❑	❑	Fatigue
❑	❑	Tachycardia / POTS	❑	❑	Neuropathy (Leg/Foot Numbness)
❑	❑	Easy Bruising/bleeding	❑	❑	Carpal Tunnel / Sciatica
❑	❑	High (or Low) Blood Pressure	❑	❑	Skin issues
❑	❑	Heart Problems	❑	❑	OTC Medications
❑	❑	High Cholesterol	❑	❑	Prescription Medications
❑	❑	Breathing problems	❑	❑	Alcohol Use
❑	❑	Allergies / Asthma	❑	❑	Tobacco Use
❑	❑	Coughing	❑	❑	Other _____

1. List any medications/supplements/Vitamins: _____
2. List all doctors you are currently seeing: _____
3. Has any Doctor or other professional referred you to the Chiropractor: ❑ No ❑ Yes, Name_____
4. Water Intake ____oz/day . Caffeine Intake ____oz./day . Alcohol Intake ____drinks/week . Tobacco Day Intake ____
   Fast Food Intake _____times/week . Vegetable/Fruit Servings ____ /day . Stress Level 1-10: ____
5. Exercise: Cardiovascular ____times/week. Resistance exercise (weights) _____ times/week
6. Commitment to make a lifestyle improvement 1-10: ____

NOTES: _____

PAST HISTORY

4. List any past auto collisions: _____ Date _____ Care received? _____
5. List any past work injuries: _____ Date _____ Care received? _____
6. List any past sport or home injuries: _____ Date _____ Care received? _____
7. Please describe any past conditions and treatment received: _____
8. Please list any past hospitalizations and surgeries: _____

NOTES: _____

FAMILY HISTORY

Father's side: □ Heart Disease □ High Cholesterol □ Cancer □ Diabetes □ Medication use □ Arthritis □ Other_____

Mother's side: □ Heart Disease □ High Cholesterol □ Cancer □ Diabetes □ Medication use □ Arthritis □ Other_____

Is there any other family history you want us to know? _____