

# Health History

Injuries/Surgeries you have had	Description	Date
Falls _____	_____	_____
Head Injuries _____	_____	_____
Broken Bones _____	_____	_____
Dislocations _____	_____	_____
Surgeries _____	_____	_____
Auto Accidents _____	_____	_____
Other _____	_____	_____

Mark only those conditions which are applicable:

- |                                              |                                              |                                               |
|----------------------------------------------|----------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> AIDS/HIV            | <input type="checkbox"/> Goiter              | <input type="checkbox"/> Pneumonia            |
| <input type="checkbox"/> Alcoholism          | <input type="checkbox"/> Gonorrhea           | <input type="checkbox"/> Polio                |
| <input type="checkbox"/> Allergy Shots       | <input type="checkbox"/> Gout                | <input type="checkbox"/> Prostate Problems    |
| <input type="checkbox"/> Anemia              | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Prosthesis           |
| <input type="checkbox"/> Anorexia            | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Psychiatric Care     |
| <input type="checkbox"/> Appendicitis        | <input type="checkbox"/> Hernia              | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Arthritis           | <input type="checkbox"/> Herniated Disc      | <input type="checkbox"/> Rheumatic Fever      |
| <input type="checkbox"/> Bleeding Disorders  | <input type="checkbox"/> Herpes              | <input type="checkbox"/> Scarlet Fever        |
| <input type="checkbox"/> Breast Lump         | <input type="checkbox"/> High Cholesterol    | <input type="checkbox"/> Stroke               |
| <input type="checkbox"/> Bronchitis          | <input type="checkbox"/> Kidney Disease      | <input type="checkbox"/> Suicide Attempt      |
| <input type="checkbox"/> Bulimia             | <input type="checkbox"/> Liver Disease       | <input type="checkbox"/> Thyroid Problems     |
| <input type="checkbox"/> Cancer              | <input type="checkbox"/> Measles             | <input type="checkbox"/> Tonsillitis          |
| <input type="checkbox"/> Cataracts           | <input type="checkbox"/> Migraine Headaches  | <input type="checkbox"/> Tuberculosis         |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Miscarriage         | <input type="checkbox"/> Tumors, Growths      |
| <input type="checkbox"/> Chicken Pox         | <input type="checkbox"/> Mononucleosis       | <input type="checkbox"/> Typhoid Fever        |
| <input type="checkbox"/> Depression          | <input type="checkbox"/> Multiple Sclerosis  | <input type="checkbox"/> Ulcers               |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Mumps               | <input type="checkbox"/> Vaginal Infections   |
| <input type="checkbox"/> Emphysema           | <input type="checkbox"/> Osteoporosis        | <input type="checkbox"/> Venereal Disease     |
| <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Pacemaker           | <input type="checkbox"/> Whooping Cough       |
| <input type="checkbox"/> Fractures           | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Other _____          |
| <input type="checkbox"/> Glaucoma            | <input type="checkbox"/> Pinched Nerve       | _____                                         |

Is there a family history of:    Heart Disease                  Arthritis                  Cancer                  Diabetes  
 Mother's side  
 Father's side

When you were a child:

Did you have a difficult birth process?    Yes    No                  Caesarean    Breach    Forceps

Did you fall or have other traumas?    Yes    No

Were you shaken, yanked or abused?    Yes    No

Have you been taught proper body movement and care?    Yes    No

## My Health Attitude- Please mark which one applies to you

- Treatment Only-** I only consult a doctor when I have an ache or a pain and discontinue as soon as it is cleared up.
- Prevention-** In addition to symptomatic treatment, I consult specialists occasionally to prevent problems from recurring.
- Maintaining Health-** I'm conscious about my health, diet, exercise, etc. and actively pursue these because I feel better, perform better and it maximizes my potential.
- Family Health-** I take an active part in assisting, informing, and maintaining health, with my family. I'm concerned with the long-term affects of good health.

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_