Dr Sheila Fahey DC | CONFIDENTIAL HEALTH HISTORY

Today's Date ________________

First Name :__________________ M.I.______Last:________________________________

Address: ____ Zip code: ______________

Date of Birth ______________ Height ___ft. ____ inches Age ______ Weight ________ lbs

Phones: Home ______________Work ______________ Cell ______________

Email: __________________________________

Occupation _______________________ Do you: ☐ sit ☐ stand ☐ lift

Emergency Contact __________________________ Relationship______________________

Phones: Home ______________ Work ______________ Cell ______________

Are you currently being treated by anyone? Yes ☐ No ☐

For what condition/s? ____

____

Previous chiropractic care? (Dr.'s names and approximate date) _________________________

____

Please list current health problems or pain, when and how they began, any other doctors seen for each condition, and any tests done, i.e. x-ray, MRI, etc.________________________________

____

____

____

____

____

____

How frequently are symptoms present?

☐ constant (76-100%) ☐ frequent (51-76%) ☐ occasional (26-50%)

☐ intermittent (less than 25%)

Place **B** for better and **W** for worse to indicate which of the following make your symptoms better or worse.

☐sitting ☐ standing ☐ inactivity ☐ lying down

☐ movement ☐ stretching ☐ other

Rate your pain intensitY (0 = no pain - 10 = worst possible) _____________________________

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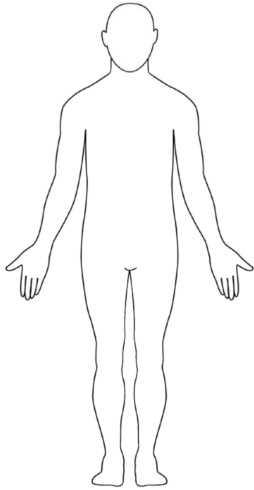
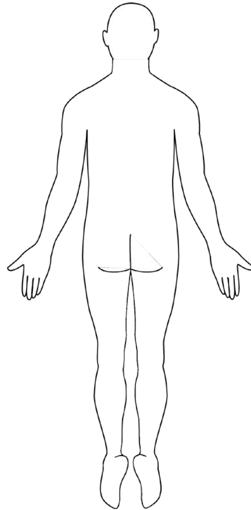
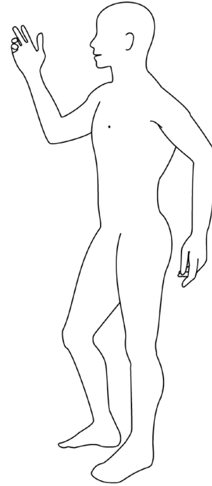
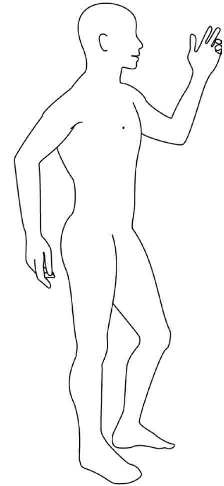
Please mark on the picture, using the letters below, to indicate the type and location of your sensations or symptoms.

Front	Back	Left Side	Right Side
			

A = ACHE | B = BURNING | N = NUMBNESS | T = THROBBING
S = STABBING or SHARP | D = DULL | X = TINGLING | O= OTHER

PAST HISTORY

Please check or describe:

Surgeries/hospitalization ☐ Appendectomy ☐ Tonsillectomy ☐ Hysterectomy

☐ Gall bladder ☐ Hernia ☐ Broken Bones

☐ Other____

Previous injuries and dates they occurred: (auto accidents, falls, sports injuries, etc.)

____

____

Have you been x-rayed in the past year? __________ Date/Location______________________

____

Family History: Please indicate below whether a family member has had or now has any of the following.

Condition	Family Member	Condition	Family Member
Arthritis		Kidney Disease	
Heart Disease		Headaches	
High Blood Pressure		Low Back Pain	
Stroke		Lupus	
Cancer		Rheumatoid Arthritis	
Diabetes		Depression	
Epilepsy		Other	

Lifestyle:

List any medications and what conditions they are prescribed for:

____

____

List any supplements you are taking:

____

____

How many glasses of water do you drink per day?____

How many hours do you sleep on average? ____

How much coffee/tea do you drink per day? ____

How much pop do you drink per day? ____

How many alcoholic beverages do you drink per week? ________________________________

Do you smoke? If so, how many packs per day? ______________________________________

How many servings of fruit/vegetables do you eat per day? _____________________________

How would you rate your stress level (mild, moderate, severe)? ___________________________

Do you stretch/exercise? What type and how often? ______________________________

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Have you ever had any of the following conditions? Please check all that apply:

Past | Now		Past | Now		Past | Now	
☐ | ☐	Angina	☐ | ☐	Tuberculosis	☐ | ☐	Migraine Headaches
☐ | ☐	Anemia	☐ | ☐	Rheumatoid Arthritis	☐ | ☐	Gallbladder Disease
☐ | ☐	Measles	☐ | ☐	Osteoporosis	☐ | ☐	Tumor or Cancer
☐ | ☐	Osteoarthritis	☐ | ☐	Meningitis	☐ | ☐	Heart Disease
☐ | ☐	Stroke	☐ | ☐	Prostatitis	☐ | ☐	Heart Attack
☐ | ☐	Pneumonia	☐ | ☐	Alcoholism	☐ | ☐	Diverticulitis
☐ | ☐	Epilepsy	☐ | ☐	Polio	☐ | ☐	Rheumatic Fever
☐ | ☐	Hepatitis: A, B, or C?	☐ | ☐	Ulcer	☐ | ☐	Bowel Obstruction
☐ | ☐	Bronchitis	☐ | ☐	Colitis	☐ | ☐	Chemical Dependency
☐ | ☐	High Blood Pressure	☐ | ☐	Gout	☐ | ☐	HIV
☐ | ☐	Emphysema	☐ | ☐	Ankylosing spondylitis	☐ | ☐	Lupus
☐ | ☐	Diabetes	☐ | ☐	Hernia	Other: please specify:	
☐ | ☐	Mumps	☐ | ☐	Thyroid Disease		
☐ | ☐	Birth Defects	☐ | ☐	Shingles /Herpes zoster		

SYMPTOMS CHECK LIST / REVIEW OF SYSTEMS

If you are having any of the following signs or symptoms of illness at the present time, or have had in the past, please indicate the symptoms that apply to you. Please check whether the problem is Now, Past, or both.

Past | Now	Feet	Past | Now	Respiratory	Past | Now	Eyes
☐ | ☐	High Arches R / L	☐ | ☐	Chronic cough	☐ | ☐	Glasses / contacts
☐ | ☐	Fallen Arches R / L	☐ | ☐	Spitting phlegm	☐ | ☐	Blurred vision
☐ | ☐	Cramps in feet or toes	☐ | ☐	Spitting blood	☐ | ☐	Vision loss R %______ L %_______
☐ | ☐	Use shoe/foot appliance R / L	☐ | ☐	Difficulty breathing	☐ | ☐	Eyes burn
☐ | ☐	Bunions *R* / L	☐ | ☐	Wheezing	☐ | ☐	Night blindness
☐ | ☐	Corns R / L	☐ | ☐	Chest pain	☐ | ☐	Pain in eyes
☐ | ☐	Calluses R / L	☐ | ☐	Allergies	☐ | ☐	Cataracts
☐ | ☐	Plantar warts R / L	☐ | ☐	Night sweats	☐ | ☐	Eyes bulge
☐ | ☐	Heel spurs R / L	☐ | ☐	Asthma	☐ | ☐	Eyes puffy
Other: Please describe:		☐ | ☐	"Rattling" in lungs	Other: Please describe:	
		☐ | ☐	Tightness in chest		
		Other: Please describe:			

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Past | Now	Urinary	Past | Now	Nose	Past | Now	Skin
☐ | ☐	Frequent urination	☐ | ☐	Sinus infection	☐ | ☐	Itching
☐ | ☐	Painful urination	☐ | ☐	Septum injury or defect	☐ | ☐	Psoriasis / Eczema
☐ | ☐	Blood in urine	☐ | ☐	Postnasal drip	☐ | ☐	Bruise easily
☐ | ☐	Kidney infection	☐ | ☐	Frequent colds	☐ | ☐	Bumps on back of arms
☐ | ☐	Bed-wetting	☐ | ☐	Allergy	☐ | ☐	Acne
☐ | ☐	Awaken at night to	☐ | ☐	Frequent sneezing	☐ | ☐	Brown spots
☐ | ☐	urinate	☐ | ☐	Change in sense of	☐ | ☐	Bronzing of skin
☐ | ☐	Kidney stones	☐ | ☐	smell	☐ | ☐	Changing mole
☐ | ☐	Difficulty passing urine	☐ | ☐	Nasal polyps	Other: Please describe:	
☐ | ☐	Bladder infections	Other: Please describe:			
Other: Please describe:					

Past | Now	Ears	Past | Now	Mouth and Throat	Past | Now	Cardiology
☐ | ☐	Hearing loss	☐ | ☐	Sore mouth	☐ | ☐	Irregular heartbeat
☐ | ☐	Wear hearing aid	☐ | ☐	Bleeding gums	☐ | ☐	Blood pressure
☐ | ☐	Discharge	☐ | ☐	Bad breath	☐ | ☐	problems
☐ | ☐	Ringing	☐ | ☐	Sore throats	☐ | ☐	Pain over heart
☐ | ☐	Ear infection	☐ | ☐	Swollen glands	☐ | ☐	Ankles swell
☐ | ☐	Mastoiditis	☐ | ☐	Wear dentures	☐ | ☐	Varicose veins
☐ | ☐	Earache(s)	☐ | ☐	Severe toothaches	☐ | ☐	Shortness of breath

<table>
<tr><th>Past | Now</th><th>Ears</th><th>Past | Now</th><th>Mouth and Throat</th><th>Past | Now</th><th>Cardiology</th></tr>
<tr><td colspan="2" rowspan="5">Other: Please describe:</td><td>☐ | ☐</td><td>Bitter taste</td><td>☐ | ☐</td><td>Cold hands and feet</td></tr>
<tr><td>☐ | ☐</td><td>Decreased salivation</td><td>☐ | ☐</td><td>Blood clots</td></tr>
<tr><td>☐ | ☐</td><td>Increased salivation</td><td>☐ | ☐</td><td>Chest pain with left arm pain</td></tr>
<tr><td colspan="2" rowspan="2">Other: Please describe:</td><td>☐ | ☐</td><td>Feel pulse in abdomen</td></tr>
<tr><td colspan="2">Other: Please describe:</td></tr>
</table>

<table>
<tr><th>Past | Now</th><th>Nervous System Psychological</th><th>Past | Now</th><th>Gastrointestinal</th><th>Past | Now</th><th>Muscle/Joint/Nerve</th></tr>
<tr><td>☐ | ☐</td><td>Depression</td><td>☐ | ☐</td><td>Poor appetite</td><td>☐ | ☐</td><td>Weakness</td></tr>
<tr><td>☐ | ☐</td><td>Excessive worry</td><td>☐ | ☐</td><td>Excessive hunger</td><td>☐ | ☐</td><td>Twitching / tics</td></tr>
<tr><td>☐ | ☐</td><td>Cry easily</td><td>☐ | ☐</td><td>Belching or gas</td><td>☐ | ☐</td><td>Neck pain</td></tr>
<tr><td>☐ | ☐</td><td>Outbursts of anger</td><td>☐ | ☐</td><td>Nausea / vomiting</td><td>☐ | ☐</td><td>Mid back pain</td></tr>
<tr><td>☐ | ☐</td><td>Forgetfulness</td><td>☐ | ☐</td><td>Difficulty swallowing</td><td>☐ | ☐</td><td>Low back pain</td></tr>
<tr><td>☐ | ☐</td><td>Awaken tired</td><td>☐ | ☐</td><td>Diarrhea</td><td>☐ | ☐</td><td>Swollen joints</td></tr>
<tr><td>☐ | ☐</td><td>Dizziness</td><td>☐ | ☐</td><td>Feel shaky or faint when hungry</td><td>☐ | ☐</td><td>Pain in tailbone</td></tr>
<tr><td>☐ | ☐</td><td>Paralysis</td><td>☐ | ☐</td><td>Crave sweets or coffee</td><td>☐ | ☐</td><td>Headaches</td></tr>
<tr><td>☐ | ☐</td><td>Incoordination</td><td>☐ | ☐</td><td>Indigestion after meals</td><td>☐ | ☐</td><td>Jaw pain / clicking</td></tr>
<tr><td>☐ | ☐</td><td>Tremors</td><td>☐ | ☐</td><td>Upset with greasy foods</td><td>☐ | ☐</td><td>Muscle spasms</td></tr>
<tr><td colspan="2" rowspan="2">Other: Please describe:</td><td>☐ | ☐</td><td>Stools light in color</td><td>☐ | ☐</td><td>Leg / foot cramps</td></tr>
<tr><td>☐ | ☐</td><td>Gallbladder attack</td><td>☐ | ☐</td><td>Shoulder pain R / L</td></tr>
</table>

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Past | Now	Nervous System Psychological	Past | Now	Gastrointestinal	Past | Now	Muscle/Joint/Nerve
		☐ ☐	Constipation / use laxatives	☐ ☐	Arm pain an/or elbow pain R *I* L
		☐ ☐	Bloody / black stool	☐ ☐	Hand and/or wrist pain R *I* L
		☐ ☐	Hemorrhoids	☐ ☐	Leg pain *R/L*
		☐ ☐	Jaundice	☐ ☐	Hip pain *RI* L
		☐ ☐	Abdominal pain/ cramps	☐ ☐	Knee pain R *I* L
		☐ ☐	Change in bowel habits	☐ ☐	Ankle pain R *I* L
		☐ ☐	Weight problem	☐ ☐	Foot pain R *I* L
		☐ ☐	Bowel movements painful	☐ ☐ Numbness or tingling, burning, "sleeping," or prickling sensation in: Arms / Hands / Legs / Feet /other R L / R L / R L / R L / R L	
		Other: Please Describe		Other: Please describe:	

Past | Now	Endocrine	Past | Now	Females
☐ | ☐	Frequent urination	Date of late period.	
☐ | ☐	Excessive thirst	Are you pregnant?	
☐ | ☐	Cold most of the time	☐ | ☐	PMS
☐ | ☐	Too warn most of the time	☐ | ☐	Menstrual cramps
☐ | ☐	Unusually tired or sluggish	☐ | ☐	Irregular periods
☐ | ☐	Unusually jumpy	☐ | ☐	Menopause symptoms
Other: Please describe:		Other: Please describe:	