

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

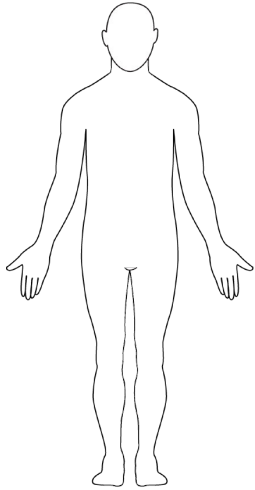
movement stretching other

Rate your pain intensity (0 = no pain - 10 = worst possible) _____

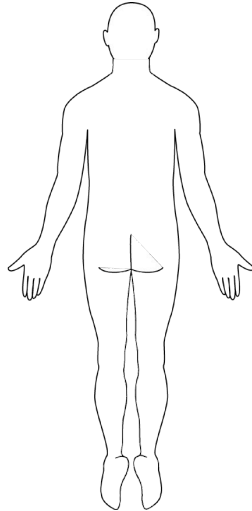
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Please mark on the picture, using the letters below, to indicate the type and location of your sensations or symptoms.

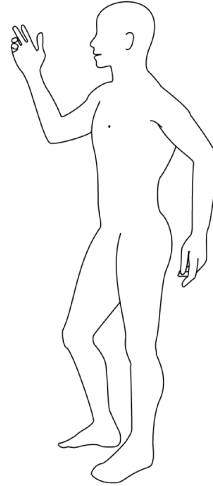
Front



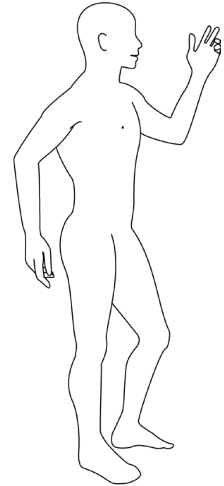
Back



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	
<input type="checkbox"/> <input type="checkbox"/>	Angina	<input type="checkbox"/> <input type="checkbox"/>	Tuberculosis	<input type="checkbox"/> <input type="checkbox"/>	Migraine Headaches
<input type="checkbox"/> <input type="checkbox"/>	Anemia	<input type="checkbox"/> <input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/> <input type="checkbox"/>	Gallbladder Disease
<input type="checkbox"/> <input type="checkbox"/>	Measles	<input type="checkbox"/> <input type="checkbox"/>	Osteoporosis	<input type="checkbox"/> <input type="checkbox"/>	Tumor or Cancer
<input type="checkbox"/> <input type="checkbox"/>	Osteoarthritis	<input type="checkbox"/> <input type="checkbox"/>	Meningitis	<input type="checkbox"/> <input type="checkbox"/>	Heart Disease
<input type="checkbox"/> <input type="checkbox"/>	Stroke	<input type="checkbox"/> <input type="checkbox"/>	Prostatitis	<input type="checkbox"/> <input type="checkbox"/>	Heart Attack
<input type="checkbox"/> <input type="checkbox"/>	Pneumonia	<input type="checkbox"/> <input type="checkbox"/>	Alcoholism	<input type="checkbox"/> <input type="checkbox"/>	Diverticulitis
<input type="checkbox"/> <input type="checkbox"/>	Epilepsy	<input type="checkbox"/> <input type="checkbox"/>	Polio	<input type="checkbox"/> <input type="checkbox"/>	Rheumatic Fever
<input type="checkbox"/> <input type="checkbox"/>	Hepatitis: A, B, or C?	<input type="checkbox"/> <input type="checkbox"/>	Ulcer	<input type="checkbox"/> <input type="checkbox"/>	Bowel Obstruction
<input type="checkbox"/> <input type="checkbox"/>	Bronchitis	<input type="checkbox"/> <input type="checkbox"/>	Colitis	<input type="checkbox"/> <input type="checkbox"/>	Chemical Dependency
<input type="checkbox"/> <input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/> <input type="checkbox"/>	Gout	<input type="checkbox"/> <input type="checkbox"/>	HIV
<input type="checkbox"/> <input type="checkbox"/>	Emphysema	<input type="checkbox"/> <input type="checkbox"/>	Ankylosing spondylitis	<input type="checkbox"/> <input type="checkbox"/>	Lupus
<input type="checkbox"/> <input type="checkbox"/>	Diabetes	<input type="checkbox"/> <input type="checkbox"/>	Hernia	Other: please specify:	
<input type="checkbox"/> <input type="checkbox"/>	Mumps	<input type="checkbox"/> <input type="checkbox"/>	Thyroid Disease		
<input type="checkbox"/> <input type="checkbox"/>	Birth Defects	<input type="checkbox"/> <input type="checkbox"/>	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
<input type="checkbox"/> <input type="checkbox"/>	High Arches R / L	<input type="checkbox"/> <input type="checkbox"/>	Chronic cough	<input type="checkbox"/> <input type="checkbox"/>	Glasses / contacts
<input type="checkbox"/> <input type="checkbox"/>	Fallen Arches R / L	<input type="checkbox"/> <input type="checkbox"/>	Spitting phlegm	<input type="checkbox"/> <input type="checkbox"/>	Blurred vision
<input type="checkbox"/> <input type="checkbox"/>	Cramps in feet or toes	<input type="checkbox"/> <input type="checkbox"/>	Spitting blood	<input type="checkbox"/> <input type="checkbox"/>	Vision loss R % _____ L % _____
<input type="checkbox"/> <input type="checkbox"/>	Use shoe/foot appliance R / L	<input type="checkbox"/> <input type="checkbox"/>	Difficulty breathing	<input type="checkbox"/> <input type="checkbox"/>	Eyes burn
<input type="checkbox"/> <input type="checkbox"/>	Bunions R / L	<input type="checkbox"/> <input type="checkbox"/>	Wheezing	<input type="checkbox"/> <input type="checkbox"/>	Night blindness
<input type="checkbox"/> <input type="checkbox"/>	Corns R / L	<input type="checkbox"/> <input type="checkbox"/>	Chest pain	<input type="checkbox"/> <input type="checkbox"/>	Pain in eyes
<input type="checkbox"/> <input type="checkbox"/>	Calluses R / L	<input type="checkbox"/> <input type="checkbox"/>	Allergies .	<input type="checkbox"/> <input type="checkbox"/>	Cataracts
<input type="checkbox"/> <input type="checkbox"/>	Plantar warts R / L	<input type="checkbox"/> <input type="checkbox"/>	Night sweats	<input type="checkbox"/> <input type="checkbox"/>	Eyes bulge
<input type="checkbox"/> <input type="checkbox"/>	Heel spurs R / L	<input type="checkbox"/> <input type="checkbox"/>	Asthma	<input type="checkbox"/> <input type="checkbox"/>	Eyes puffy
Other: Please describe:		<input type="checkbox"/> <input type="checkbox"/>	"Rattling" in lungs	Other: Please describe:	
		<input type="checkbox"/> <input type="checkbox"/>	Tightness in chest		
		Other: Please describe:			

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Past Now	Urinary	Past Now	Nose	Past Now	Skin
<input type="checkbox"/> <input type="checkbox"/>	Frequent urination	<input type="checkbox"/> <input type="checkbox"/>	Sinus infection	<input type="checkbox"/> <input type="checkbox"/>	Itching
<input type="checkbox"/> <input type="checkbox"/>	Painful urination	<input type="checkbox"/> <input type="checkbox"/>	Septum injury or defect	<input type="checkbox"/> <input type="checkbox"/>	Psoriasis / Eczema
<input type="checkbox"/> <input type="checkbox"/>	Blood in urine	<input type="checkbox"/> <input type="checkbox"/>	Postnasal drip	<input type="checkbox"/> <input type="checkbox"/>	Bruise easily
<input type="checkbox"/> <input type="checkbox"/>	Kidney infection	<input type="checkbox"/> <input type="checkbox"/>	Frequent colds	<input type="checkbox"/> <input type="checkbox"/>	Bumps on back of arms
<input type="checkbox"/> <input type="checkbox"/>	Bed-wetting	<input type="checkbox"/> <input type="checkbox"/>	Allergy	<input type="checkbox"/> <input type="checkbox"/>	Acne
<input type="checkbox"/> <input type="checkbox"/>	Awaken at night to	<input type="checkbox"/> <input type="checkbox"/>	Frequent sneezing	<input type="checkbox"/> <input type="checkbox"/>	Brown spots
<input type="checkbox"/> <input type="checkbox"/>	urinate	<input type="checkbox"/> <input type="checkbox"/>	Change in sense of	<input type="checkbox"/> <input type="checkbox"/>	Bronzing of skin
<input type="checkbox"/> <input type="checkbox"/>	Kidney stones	<input type="checkbox"/> <input type="checkbox"/>	smell	<input type="checkbox"/> <input type="checkbox"/>	Changing mole
<input type="checkbox"/> <input type="checkbox"/>	Difficulty passing urine	<input type="checkbox"/> <input type="checkbox"/>	Nasal polyps	Other: Please describe:	
<input type="checkbox"/> <input type="checkbox"/>	Bladder infections	Other: Please describe:			
Other: Please describe:					
Past Now	Ears	Past Now	Mouth and Throat	Past Now	Cardiology
<input type="checkbox"/> <input type="checkbox"/>	Hearing loss	<input type="checkbox"/> <input type="checkbox"/>	Sore mouth	<input type="checkbox"/> <input type="checkbox"/>	Irregular heartbeat
<input type="checkbox"/> <input type="checkbox"/>	Wear hearing aid	<input type="checkbox"/> <input type="checkbox"/>	Bleeding gums	<input type="checkbox"/> <input type="checkbox"/>	Blood pressure
<input type="checkbox"/> <input type="checkbox"/>	Discharge	<input type="checkbox"/> <input type="checkbox"/>	Bad breath	<input type="checkbox"/> <input type="checkbox"/>	problems
<input type="checkbox"/> <input type="checkbox"/>	Ringing	<input type="checkbox"/> <input type="checkbox"/>	Sore throats	<input type="checkbox"/> <input type="checkbox"/>	Pain over heart
<input type="checkbox"/> <input type="checkbox"/>	Ear infection	<input type="checkbox"/> <input type="checkbox"/>	Swollen glands	<input type="checkbox"/> <input type="checkbox"/>	Ankles swell
<input type="checkbox"/> <input type="checkbox"/>	Mastoiditis	<input type="checkbox"/> <input type="checkbox"/>	Wear dentures	<input type="checkbox"/> <input type="checkbox"/>	Varicose veins
<input type="checkbox"/> <input type="checkbox"/>	Earache(s)	<input type="checkbox"/> <input type="checkbox"/>	Severe toothaches	<input type="checkbox"/> <input type="checkbox"/>	Shortness of breath

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Past Now	Ears	Past Now	Mouth and Throat	Past Now	Cardiology
Other: Please describe:		<input type="checkbox"/> <input type="checkbox"/>	Bitter taste	<input type="checkbox"/> <input type="checkbox"/>	Cold hands and feet
		<input type="checkbox"/> <input type="checkbox"/>	Decreased salivation	<input type="checkbox"/> <input type="checkbox"/>	Blood clots
		<input type="checkbox"/> <input type="checkbox"/>	Increased salivation	<input type="checkbox"/> <input type="checkbox"/>	Chest pain with left arm pain
		Other: Please describe:		<input type="checkbox"/> <input type="checkbox"/>	Feel pulse in abdomen
				Other: Please describe:	

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

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Past Now	Nervous System Psychological	Past Now	Gastrointestinal	Past Now	Muscle/Joint/Nerve	
		<input type="checkbox"/> <input type="checkbox"/>	Constipation / use laxatives	<input type="checkbox"/> <input type="checkbox"/>	Arm pain an/or elbow pain R / L	
		<input type="checkbox"/> <input type="checkbox"/>	Bloody / black stool	<input type="checkbox"/> <input type="checkbox"/>	Hand and/or wrist pain R / L	
		<input type="checkbox"/> <input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/> <input type="checkbox"/>	Leg pain <i>R/L</i>	
		<input type="checkbox"/> <input type="checkbox"/>	Jaundice	<input type="checkbox"/> <input type="checkbox"/>	Hip pain <i>R/L</i>	
		<input type="checkbox"/> <input type="checkbox"/>	Abdominal pain/ cramps	<input type="checkbox"/> <input type="checkbox"/>	Knee pain <i>R / L</i>	
		<input type="checkbox"/> <input type="checkbox"/>	Change in bowel habits	<input type="checkbox"/> <input type="checkbox"/>	Ankle pain <i>R / L</i>	
		<input type="checkbox"/> <input type="checkbox"/>	Weight problem	<input type="checkbox"/> <input type="checkbox"/>	Foot pain <i>R / L</i>	
		<input type="checkbox"/> <input type="checkbox"/>	Bowel movements painful	<input type="checkbox"/> <input type="checkbox"/> 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:	

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Past Now	Endocrine	Past Now	Females
<input type="checkbox"/> <input type="checkbox"/>	Frequent urination	Date of late period.	
<input type="checkbox"/> <input type="checkbox"/>	Excessive thirst	Are you pregnant?	
<input type="checkbox"/> <input type="checkbox"/>	Cold most of the time	<input type="checkbox"/> <input type="checkbox"/>	PMS
<input type="checkbox"/> <input type="checkbox"/>	Too warm most of the time	<input type="checkbox"/> <input type="checkbox"/>	Menstrual cramps
<input type="checkbox"/> <input type="checkbox"/>	Unusually tired or sluggish	<input type="checkbox"/> <input type="checkbox"/>	Irregular periods
<input type="checkbox"/> <input type="checkbox"/>	Unusually jumpy	<input type="checkbox"/> <input type="checkbox"/>	Menopause symptoms
Other: Please describe:		Other: Please describe:	