GARDINER FAMILY CHIROPRACTIC
PATIENT HEALTH HISTORY Side 1 of 2

Full Name:____Date:_______________

Please indicate next to each applicable disease/condition whether you have it Now (N) or have had in the Past (P):

Pain or numbness of the -	___ Loss of appetite	___ Depression/Bipolar Disorder	___ Kidney disorders
___ Neck ___ Shoulder	___ Anorexia	___ Aortic aneurysm	___ Colitis
___ Upper arm or elbow	___ Abnormal weight loss	___ High blood pressure	___ HIV / AIDS
___ Hand ___ Wrist	___ Abnormal weight gain	___ Angina	___ Systemic lupus
___ Upper back	___ Excessive thirst	___ Heart attack	___ Herpes/Shingles
___ Lower back	___ Chronic cough	___ Stroke	___ Other_______________
___ Upper leg or hip	___ Chronic sinusitis	___ Asthma	___ Loss of sleep
___ Lower leg or knee	___ General fatigue	___ Cancer	___ Heart surgery / pacemaker
___ Ankle or foot	___ Irregular menstrual flow	___ Tumor	___ Heart murmer
___ Jaw	___ Breast soreness/lumps	___ Prostate problems	___ Congenital heart defect
___ Swelling/stiffness of joints	___ Endometriosis	___ Blood disorder	___ Low blood pressure
___ Fainting	___ PMS	___ Emphysema (chronic lung disorder)	___ Tuberculosis
___ Visual disturbances	___ Loss of bladder control	___ Arthritis	___ Alcohol / drug abuse
___ Convulsions	___ Painful urination	___ Rheumatoid arthritis	___ Venereal disease
___ Dizziness	___ Frequent urination	Diabetes: __Type I __ Type II	___ Rheumatic fever
___ Headache	___ Abdominal Pain	___ Ulcer	___ Thyroid problems
___ Muscular incoordination	___ Constipation/irreg. bowel habits	___ Liver/gallbladder problem	___ Psychiatric problems
___ Tinnitus (ear noises)	___ Difficulty in swallowing	___ Kidney stones	___ Surgeries
___ Rapid heart beat	___ Heartburn/indigestion	___ Hepatitis	
___ Chest pains	___ Dermatitis/Eczema/Rash	___ Bladder infection	

Please indicate beside each applicable activity whether you engage in it Often (O) or Sometimes (S)

___ Horseback riding	___ Jogging (mile or less)	___ Football	___ Gardening
___ Bowling	___ Jogging (> a mile)	___ Tennis	___ Climbing stairs
___ Golf	___ Dancing	___ Gymnastics	___ Meditation
___ Volleyball	___ Scuba diving	___ Skiing	___ Yoga
___ Baseball/Softball	___ Backpacking	___ Water skiing	___ Pilates
___ Handball	___ Swimming	___ Hunting	___ Child care:
___ Racquetball	___ Aerobics	___ Fishing	Ages(s):___________
___ Basketball	___ Resistance training	___ Lawn mowing	Weight(s):_________
___ Walking (mile or less)	___ Free weights	___ Weed eater use	___ Other_____________
___ Walking (> a mile)	___ Exercise machines	___ Snow shoveling	

Please indicate if you have experienced any of the following in the last 5 years:

___ Marriage	___ Death of a family member or friend	___ Change in job
___ Birth/adoption of a child	___ Handicapped household member	___ Loss of job
___ Divorce	___ Caregiver to family member	___ Change in living conditions
___ Death of a spouse	___ Retirement	___ Change in residence
___ Marital separation	___ Dependence problems	___ Change in financial status
	___ alcohol ___drugs	

Personal Habits

Do you use alcohol? ___Yes ___No
If yes: How often______________ Amount ________________
Do you smoke? ___Yes ___No
If yes: Since when_________________ Packs per day______
If you quit smoking, when?______________________________
Do you use illegal drugs? ___Yes ___No
If yes: Type__________________ How often_____________
Do you drink ___coffee ___tea ___soda
If yes: Amount__________ Cups(8oz) per ___day ___week
Do you wear: ___heel lifts ___sole lifts __inner soles
___arch supports If yes: Custom made? ___Yes ___No

Family History

Is your mother ___alive or ___deceased?
If deceased, cause of death_____________________
Is your father ___alive or ___deceased?
If deceased, cause of death_____________________
Do you have a family history of any of the following?
___Heart disease ___High blood pressure
___Diabetes ___Stroke
___Cancer ___Thyroid disease

DO NOT WRITE IN THIS SPACE:

PLEASE COMPLETE BOTH SIDES OF THIS FORM