General Health History

Deines Chiropractic
307-673-5075
1821 S. Sheridan Ave
Sheridan Wy, 82801

Patient Name: _____

Mark the conditions that apply to you.

- ☐ Headaches
- ☐ Migraines
- ☐ Shortness of Breath
- ☐ Allergies / Asthma
- ☐ Medication Side Effects
- ☐ Diabetes
- ☐ Hands or Feet cold
- ☐ Muscle aches
- ☐ Trouble Walking
- ☐ Leg / Foot Numbness
- ☐ Fainting
- ☐ Gall Bladder Trouble
- ☐ Ringing in Ears
- ☐ Sleeping Problems
- ☐ Vision Problems
- ☐ Thyroid Problems
- ☐ Liver Disease
- ☐ Kidney Problems
- ☐ Light Bothers Eyes
- ☐ Other_____
- ☐ Urinary Problems
- ☐ Easy Bruising
- ☐ Tobacco Use
- ☐ Dental Problems
- ☐ Fibromyalgia
- ☐ Blood Thinner use
- ☐ HIV Positive
- ☐ Cancer
- ☐ Depression
- ☐ Alcohol Use
- ☐ High or Low Blood pressure
- ☐ Stroke History
- ☐ High Cholesterol
- ☐ TMJ
- ☐ Digestive Problems
- ☐ Pain All Over
- ☐ Tension / Irritability
- ☐ Chest Pain
- ☐ Heart Pacemaker
- ☐ Heart Problems

List and medications you are taking: _____

Please list all Doctors you are currently seeing: _____

Has any Doctor or other professional advised you to "Go to a Chiropractor": _____

List any past auto collisions: _____ **Was any care received?** _____

List and past work injuries: _____ **Was any care received?** _____

List any past sport, recreational, or home injuries: _____

Please describe and past conditions & treatments received: _____

_____

Please list any past hospitalizations and surgeries: _____

_____

Life Activities

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life.

N- No effect
P- Painful (can do)
L- Painful (limited)
U- Unable to Perform

- _____Carrying Children/Groceries
- _____Sit to Stand
- _____Climb Stairs
- _____Look over shoulder
- _____Read/Concentrate
- _____Extended Computer Use
- _____Getting Dressed
- _____Exercise
- _____Sexual Activities
- _____Sleep
- _____Static Sitting
- _____Static Standing
- _____Yard Work
- _____Washing/Bathing
- _____House Work
- _____Driving
- _____Social Life
- _____Other: _____

Father's side: ☐ Heart Disease ☐ Cancer ☐ Diabetes ☐ Heavy Medication use ☐ Arthritis ☐ Other _____

Mother's side: ☐ Heart Disease ☐ Cancer ☐ Diabetes ☐ Heavy Medication use ☐ Arthritis ☐ Other _____

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