



## Past Health History

Surgeries/Operations: ( )Appendix ( )Tonsils ( )Hernia  
( )Spinal ( )Cosmetic \_\_\_\_\_ ( )Other \_\_\_\_\_

Major accidents or falls since birth \_\_\_\_\_

Hospitalizations \_\_\_\_\_

If currently getting treated for another condition, please list the condition \_\_\_\_\_

Is there anything else you would like the doctor to know about your health? \_\_\_\_\_

**Please check any of the following that you or someone in your family have ever had in the past.**

- ( )Pneumonia ( )Mumps ( )Measels  
( )Arthritis ( )Heart Disease ( )Pleurisy  
( )Tuberculosis ( )Thyroid Dis. ( )Influenza  
( )Polio ( )Cancer ( )Anemia  
( )Small Pox ( )Rheumatic Fever  
( )Eczema/Psoriasis ( )Whooping Cough

**Please check all of the following conditions that you have had in the past six months.**

### Musculoskeletal

- ( )Low back pain ( )Pain between the shoulders  
( )Neck pain ( )Shoulder/Arm/Wrist pain  
( )Hip/Knee/Ankle pain ( )Joint pain or stiffness  
( )Difficulty walking ( )Jaw/Head pain

### Nervous System

- ( )Cold/Tingling extremities ( )Dizziness  
( )Numbness/Loss of sensation ( )Fainting  
( )Forgetfulness ( )Depression  
( )Seizures ( )Paralysis  
( )Nervousness ( )Stress

### Gastrointestinal System

- ( )Poor app./Underweight ( )Excessive thirst  
( )Excessive app./Overweight ( )Frequent nausea  
( )Vomiting ( )Diarrhea  
( )Constipation ( )Hemorrhoids  
( )Liver problems ( )Gall bladder problems  
( )Abdominal cramps ( )Heartburn  
( )Gas/Bloating after meals ( )Blood in stool  
( )Colitis/Chron's/IBS

### Genitourinary

- ( )Painful/Excessive urination ( )Discolored urine  
( )Bladder infections ( )Urinary leakage

### EENT

- ( )Vision problems ( )Dental problems  
( )Earache/Infections ( )Difficulty hearing  
( )Ringing in the ears ( )Colds/Flu  
( )Sinus problems ( )Sore throat

### Cardiovascular

- ( )Chest pain ( )Shortness of breath  
( )Heart problem ( )High blood pressure  
( )Varicose veins ( )Ankle swelling ( )Irreg heart beat  
( )Stroke ( )Lung symptoms/Congestion

### General

- ( )Fatigue ( )Loss of sleep ( )Headaches  
( )Allergies ( )Unexplained fevers ( )Bruise easily  
( )Hives or Rashes

### Male Only

- ( )Prostate dysfunction ( )Sexual dysfunction  
( )Loss of libido

### Female Only

- ( )Menstrual cramps ( )Irregular/Absent periods  
( )PMS ( )Vaginal pain/Infections  
( )Loss of libido ( )Menopausal symptoms  
( )Breast pain ( )Uterine/Ovarian fibroids

Date of last period? \_\_\_\_\_

Are you pregnant? ( )Yes ( )No ( )Not sure

Other health issues \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Medications

(Please list all you currently take)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Allergies

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Vitamins/Herbs/Supplements

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What do you commonly eat for breakfast?

Lunch \_\_\_\_\_

Dinner \_\_\_\_\_

Snacks \_\_\_\_\_

Do you drink alcohol? ( )Yes ( )No Type \_\_\_\_\_

Do you drink coffee? ( )Yes ( )No How much \_\_\_\_\_

Do you drink soda? ( )Yes ( )No How much \_\_\_\_\_

Do you use ( )Sugar ( )Artificial sweeteners

How much water do you drink per day? \_\_\_\_\_

How many hours of sleep per night? \_\_\_\_\_

Do you wake feeling rested? ( )Yes ( )No

How often do you exercise? \_\_\_\_\_

Please describe exercise regimen/physical activity.

\_\_\_\_\_

## Mental/Emotional Health History

Scientific studies are now showing that emotional stress has a great deal to do with our health. Please answer the following questions as accurately and completely as possible.

Please rate the following areas of potential stress on a scale of 1-10, with 10 being the highest stress you could imagine and 1 being relatively no stress.

<b>Please circle the appropriate number:</b>	<b>High</b>									<b>Low</b>
Financial/Money matters	10	9	8	7	6	5	4	3	2	1
Relationship/Family matters	10	9	8	7	6	5	4	3	2	1
Job/Career/Education	10	9	8	7	6	5	4	3	2	1
Current level of health	10	9	8	7	6	5	4	3	2	1
Spiritual/Religious/Ethical matters	10	9	8	7	6	5	4	3	2	1
Overall level of life stress	10	9	8	7	6	5	4	3	2	1

Dr. Christine Hoffmann is a specialist in NET (Neuro-Emotional Technique). She is able to determine through this method if stress is affecting your present condition and overall health. She will discuss this with you during your office visit. If she can show you how your health can improve and your level of stress can be dramatically reduced, would you be interested in learning more about this technique? ( )Yes ( )No

## Goals for Your Care

I would like to thank you for choosing this office for your chiropractic and healthcare needs. It is my primary goal to provide you with the highest level of health care available. I understand that people see chiropractors for a variety of reasons. Some go just for pain relief, some want to correct the **cause** of their pain/symptoms, and there are still others who choose overall life and health enhancement by correcting all areas of dysfunction going on in their bodies, even before any symptoms are present.

Please check the type of care desired so that I can best serve your health needs.

- ( ) Relief care: Pain/Symptom relief only
- ( ) Corrective care: Correction of the **cause** of the pain/symptoms, as well as, relief of the pain/symptoms
- ( ) Comprehensive care: Bring all areas of the body that are malfunctioning to the highest state of health possible, while correcting the cause and providing symptom relief to the areas of complaint
- ( ) I want the doctor to select the type of care appropriate for my health condition