Medical History Form

Full Name *

First Name Middle Name Last Name

Date of Birth *

Month Day Year

What is your gender? *

Contact Number *

Email Address *

example@example.com

Why are you here today, what problems can we address, and the history surrounding these problems. *

Last dental exam and cleaning *

Month Day Year

Last yearly vision screening/exam. *

Month Day Year

Last Physical *

Month Day Year

For women: Last menstrual period, number of days between cycles, regular/irregular, length of cycle, any issues with cycle?

Past surgeries and dates of surgeries

Other past medical history

Check the symptoms that you' re currently experiencing: General ROS: *

- Weight Change
- Fever, Chills
- Night Sweats
- Fatigue or Tiredness
- Malaise or Overall poor feeling
- NONE OF THESE

Check the symptoms that you' re currently experiencing: HEENT: *

Hearing changes	Ear pain	Nasal congestion	Sinus pain
Hoarseness	Sore Throat	Runny/stuffy nose	Swallowing difficulty
Eye pain, swelling or redness	Eye Discharge	Vision changes	NONE OF THESE

Check the symptoms that you' re currently experiencing: Cardiac: *

Chest Pain	Shortness of breath	Shortness of breath on Exertion, Swelling in hands or feet	Palpitations (racing/fluttering heart)
NONE OF THESE			

Check the symptoms that you' re currently experiencing: Respiratory: *

Cough	Sputum	Wheezing	Smoke exposure
Shortness of breath	NONE OF THESE		

Check the symptoms that you' re currently experiencing: GI: *

Nausea	Vomiting	Diarrhea	Constipation
Abdominal pain	Heartburn or Reflux	Cough at night while lying down	Sore Throat upon waking in the morning
Loss of appetite	Dysphagia or difficulty swallowing	Blood when vomiting	Blood in stool
Flatulence or excessive gas	Jaundice or yellowing of skin	NONE OF THESE	

Check the symptoms that you' re currently experiencing: Musculoskeletal: *

Joint pain	Joint swelling	Joint stiffness	Back pain
Neck pain	Generalized muscle pain	History of recurrent injuries	NONE OF THESE

Check the symptoms that you' re currently experiencing: Skin: *

Skin lesions	Skin itching	Hair changes	Breast/Skin changes
NONE OF THESE			

Check the symptoms that you' re currently experiencing: Urinary: *

Painful menstrual periods	Pain intercourse	Painful urination	Increased urinary frequency
Blood in urine	Urinary leakage when I cough, squat, stand, laugh	Urgency to urinate	Flank or side pain
Urinary flow changes	Hesitancy or Issue starting/stopping urine flow	NONE OF THESE	

Check the symptoms that you' re currently experiencing: Neuro: *

Brain fog	Poor concentration/memory	Weakness	Numbness
Tingling or loss of sensation in hands and feet	Loss of consciousness	Fainting or Near Fainting when standing up	Dizziness
Headaches	Migraines	Coordination changes	Recent falls
NONE OF THESE			

Check the symptoms that you' re currently experiencing: Mental Health: *

Panic Attacks	Excessive worry or Anxiety	Low mood, feeling down	Difficulty sleeping
Personality changes	Delusions	Rumination or hyper-focusing on an issue or thought	Social issues
Memory changes	Violence/Abuse (current or history of)	Eating concerns or changes in eating patterns	NONE OF THESE

Check the symptoms that you' re currently experiencing: Heme/Lymph: *

Easy bruising	Increased bleeding	Transfusions history	Swollen lymph nodes
NONE OF THESE			

Check the symptoms that you' re currently experiencing: Endocrine: *

Increased frequency of urination	Increased thirst	Increase appetite	Temperature intolerance -sensitive to extreme heat or extreme cold
Hair falling out or Hair is coarse	Hair is increasing in thickness, velvety soft	NONE OF THESE	

Of the symptoms you checked 'YES': When did they start, how often do they occur, does anything make them better or worse? *

Check the conditions that apply to you or any member of your immediate relatives:

Asthma	Cancer
Cardiac disease	Diabetes
Hypertension	Psychiatric disorder
Epilepsy	Other

Are you currently taking any medication?

Yes No

Do you have any allergies (medication or environmental)?

Yes No Not Sure

Do you use any kind of tobacco or have you ever used them?

Do you use any kind of illegal drugs or have you ever used them?

How often do you consume alcohol?

Daily Weekly Monthly Occasionally Never

Are you are interested in any of the other services we offer:

Chiropractic Care	Physical Therapy	Acupuncture	Massage Therapy
Dry Needling	Nasal Release Technique	Postural Restoration	NONE OF THESE