Marconi Chiropractic and Wellness 1002 MLK Jr Way Tacoma, WA 98405

# Personal Health History

All information will be kept strictly confidential. Your responses will help determine if alternative treatment will benefit you. Unless we sincerely feel that your condition will respond satisfactorily, we will not recommend treatment.

___________________________________________________________________________

(Name) (Date of Birth) (Today's Date)

Please circle the conditions you currently have or have had. To be responsible for your case, we need your complete health history.

**Muscle / Joint**
- ± Arthritis
- ± Bursitis
- ± Foot trouble
- ± Hernia
- ± Low back pain
- ± Buttock pain
- ± Neck pain, stiffness
- ± Pain between shoulders

**General**
- ± Allergy
- ± Chills
- ± Convulsions
- ± Dizziness
- ± Fainting
- ± Fatigue
- ± Fever
- ± Headache
- ± Loss of sleep
- ± Loss of weight
- ± Nervousness, depression
- ± Neuralgia
- ± Numbness
- ± Sweats
- ± Tremors

**Cardiovascular**
- ± Hardening of arteries
- ± High blood pressure
- ± Low blood pressure
- ± Pain over heart
- ± Poor circulation
- ± Rapid heartbeat
- ± Slow heartbeat
- ± Swelling of ankles

**Genitourinary**
- ± Bed-wetting
- ± Blood in urine
- ± Frequent urination
- ± Lack of kidney control
- ± Kidney infection
- ± Painful urination
- ± Prostate trouble
- ± Pus in urine

**Eye, Ear, Nose and Throat**
- ± Asthma
- ± Colds
- ± Crossed eyes
- ± Deafness
- ± Dental decay
- ± Earache
- ± Ear discharge
- ± Ear noise
- ± Enlarged glands
- ± Enlarged thyroid
- ± Eye pain
- ± Failing vision
- ± Far sightedness
- ± Gum trouble
- ± Hay fever
- ± Hoarseness
- ± Nasal obstruction
- ± Near sightedness
- ± Nose bleeds
- ± Sinus infection
- ± Sore throat
- ± Tonsillitis

**Gastrointestinal**
- ± Belching or gas
- ± Colitis
- ± Colon trouble
- ± Constipation
- ± Diarrhea
- ± Difficult digestion
- ± Bloated abdomen
- ± Excessive hunger
- ± Gallbladder trouble
- ± Hemorrhoids
- ± Intestinal worms
- ± Jaundice
- ± Liver trouble
- ± Nausea
- ± Pain over stomach
- ± Poor appetite
- ± Vomiting
- ± Vomiting of blood

**Skin**
- ± Boils
- ± Bruise easily
- ± Dryness
- ± Hives or allergy
- ± Itching
- ± Skin eruptions (rash)
- ± Varicose veins

**Pain or numbness in**
- ± Shoulders
- ± Arms
- ± Elbows
- ± Hands
- ± Hips
- ± Legs
- ± Knees
- ± Feet
- ± Painful tailbone
- ± Poor posture
- ± Sciatica
- ± Spinal curvature
- ± Swollen joints

**Respiratory**
- ± Chest pain
- ± Chronic cough
- ± Difficult breathing
- ± Spitting up blood
- ± Spitting up phlegm
- ± Wheezing

**Women only**
- ± Congested breasts
- ± Cramps or backache
- ± Excess menstrual flow
- ± Hot flashes
- ± Irregular cycle
- ± Lumps in breast
- ± Menopause
- ± Painful menstruation
- ± Vaginal discharge

Are you pregnant? ± Yes ± No

If yes, how many months? ________

How many children do you have? ________

*Check any of the following conditions you currently have or have had:*
- ± Alcoholism
- ± Anemia
- ± Appendicitis
- ± Arteriosclerosis
- ± Cancer
- ± Chicken pox
- ± Cholera
- ± Cold sores
- ± Diabetes
- ± Diptheria
- ± Eczema
- ± Edema
- ± Emphysema
- ± Epilepsy
- ± Fever blisters
- ± Goiter
- ± Gout
- ± Heart disease
- ± Herpes
- ± Influenza
- ± Lumbago
- ± Malaria
- ± Measles
- ± Miscarriage
- ± Multiple sclerosis
- ± Mumps
- ± Pacemaker
- ± Pleurisy
- ± Pneumonia
- ± Polio
- ± Rheumatic fever
- ± Scarlet fever
- ± Stroke
- ± Tuberculosis
- ± Typhoid fever
- ± Ulcers
- ± Venereal disease
- ± Whooping cough

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Describe problem:___________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

How long have you had this condition? ___________ Is it getting worse? ± Yes ± No

What seemed to be the initial cause: ___________________________________________

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Name________________________ Height__________ Weight ____________ Date______________________

Have you seen a chiropractor before? ± Yes ± No If yes, how long ago? __________

For what reason? ______________________________________________________________

Have you seen an acupuncturist before? ___Yes ___No If yes, how long ago?____________

For what reason? ______________________________________________________________.

Have you seen a massage therapist before? ___Yes ___No If yes, how long ago?________________

For what reason?______________________________________________________________.

Have you seen a reiki master before? ___Yes ___No If yes, how long ago?____________

For what reason? ______________________________________________________________.

Have you seen a life coach/nutritionist before? ___Yes ___No If yes, how long ago?________________

For what reason?______________________________________________________________.

Please describe your diet______________________________________________________________

______________________________________________________________

______________________________________________________________

Are you under the care of a physician? ± Yes ± No If yes, for what reason? ______________________________

Have you been hospitalized in the last 5 years? ± Yes ± No If yes, for what reason?

Have you had any mental or emotional disorders? ± Yes ± No If yes, when?

______________________________________________________________

Indicate the medication you now take? ______________________________________________________________

| Have you ever: | Yes | No | If yes, briefly explain. |
|---|---|---|---|
| - had a broken bone? | ± | ± | |
| - been hospitalized? | ± | ± | |
| - had strains or sprains? | ± | ± | |
| - used a cane, crutch or other support? | ± | ± | |
| - been struck unconscious? | ± | ± | |
| - been hospitalized for other than surgery? | ± | ± | |

| Do you: | Yes | No | |
|---|---|---|---|
| - take minerals, herbs or vitamins? | ± | ± | |
| - think you need minerals, herbs or vitamins? | ± | ± | |
| - have any drug allergy? | ± | ± | |

| When did you last have: | Never | 0-6 mos. | 6 -18 mos. | longer |
|---|---|---|---|---|
| - spinal x-ray? | ± | ± | ± | ± |
| - spinal examination? | ± | ± | ± | ± |
| - physical examination? | ± | ± | ± | ± |

| HABITS | None | Light | Mod | Heavy |
|---|---|---|---|---|
| Alcohol | ± | ± | ± | ± |
| Coffee | ± | ± | ± | ± |
| Tobacco | ± | ± | ± | ± |
| Drugs | ± | ± | ± | ± |
| Exercise | ± | ± | ± | ± |
| Sleep | ± | ± | ± | ± |
| Appetite | ± | ± | ± | ± |
| Soft Drinks | ± | ± | ± | ± |
| Salty Foods | ± | ± | ± | ± |
| Water | ± | ± | ± | ± |
| Sugar | ± | ± | ± | ± |
| Sweeteners | ± | ± | ± | ± |

With your present condition – does it affect your activities of daily life? Ex: doing dishes, laundry, walking, sitting, travel, sleeping? List all below

______________________________________________________________

______________________________________________________________

______________________________________________________________

FAMILY HEALTH HISTORY

Some health conditions are the result of hereditary spinal weaknesses. Information about your immediate family members, brothers, sisters, parents, and grandparents will give us a better understanding of your total health picture.

| RELATIONSHIP | PRESENT AND PAST HEALTH PROBLEMS |
|---|---|
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