# Update Health History Form

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Lawrence, KS 66049
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## PERSONAL DATA:

Today's Date ____________

Name (first middle last) ______________________ Date of Birth ______________

Home Address ______________________ City ______________ State ______ Zip ________

Cell (____) ______________ Work (____) ______________ Home (____) ______________

E-mail address ______________________ Gender: M / F Marital Status ______________

Occupation ______________________ Employer ______________________

Emergency Contact ______________________ Primary Phone ______________________

Secondary Phone ______________________ Relation to Patient ______________________

## FINANCIAL INFORMATION:

Any change in responsible party or insurance coverage? ❑ Yes ❑ No

## REASON FOR SEEKING CHIROPRACTIC CARE:

**Pick all areas you are interested in receiving or learning more information about:**

❑ Pain Relief ❑ Nutrition ❑ Kinesiology Taping (RockTape) ❑ Acupuncture ❑ Posture
❑ Exercise Plan ❑ Leaky Gut ❑ Reducing Lifestyle Toxins ❑ Body Cleanse ❑ Massage
❑ Relief & Prevention of Symptoms ❑ Healthier spine & nerve system ❑ Optimal Health ❑ Other

**Describe Major Complaint** ______________________________________

**Describe WHEN and HOW this began** ______________________________________

______________________________________

**Quality of Complaint** ❑ Sharp ❑ Stabbing ❑ Burning ❑ Achy ❑ Dull ❑ Stiff & Sore ❑ Other
**Does this complaint radiate/shoot to any areas of your body?** ❑ No ❑ Yes -*Location* ______________
**Severity of Complaint** ❑ None (0) ❑Mild (1-2) ❑Mild-Mod (2-4) ❑Moderate (4-6) ❑Mod-Severe (6-8) ❑Severe (8-10)
**Frequency** ❑ Always ❑ Hourly ❑ Daily ❑ Occasionally
**Daily activities affected by this condition (Please check all that apply)**
❑ Work/School ❑ Exercise/Sports ❑ Driving ❑ Walking ❑ Sleep
❑ Sitting ❑ Stairs ❑ Love Life ❑ Eating ❑ Other activities
**Please explain** ______________________________________
**Aggravates Condition** ❑ Sit ❑ Stand ❑ Walk ❑ Lying ❑ Sleep ❑ Overuse ❑ Other ______________
**Improves Condition** ❑ Ice ❑ Heat ❑ Rest ❑ Movement ❑Stretching ❑ OTC Meds ❑ Other ______________
**For this CURRENT condition, have you:**
**Received any treatment?** ❑ None ❑ DC ❑ MD ❑ PT ❑ Massage ❑ ER ❑ Other ______________
If yes, explain ______________________________________
**Diagnostic Testing?** ❑ None ❑ X-Rays ❑ MRI ❑ CT ❑ Other ______________

**Describe Additional Complaints** ______________________________________

______________________________________

______________________________________

## HEALTH CARE PRACTITIONER HISTORY:

Primary Care Physician ______________________ Doctor's Phone ______________________

**Have you consulted any of the following providers in the past year?** (check all that apply)
❑ 1. Medical Physician ❑ 3. Naturopath ❑ 5. Acupuncturist ❑ 7. Homeopath
❑ 2. Massage Therapist ❑ 4. Psychotherapist ❑ 6. Energy Healer ❑ 8. Dentist
Describe: ______________________________________

______________________________________

# Updated Health History Cont.

**Vertebral Subluxations can have Physical, Emotional and Chemical causes and effects**

**The primary system in the body which coordinates health is the NERVE SYSTEM. The vertebrae (bones of the spinal column) surround and protect the delicate NERVE SYSTEM. Injury to the SPINE and NERVE SYSTEM is a condition called VERTEBRAL SUBLUXATION. VERTEBRAL SUBLUXATION results in nerve malfunction due to vertebral/spinal misalignment.**

The following information will help us to see the types of **PHYSICAL, EMOTIONAL & CHEMICAL** stresses you have been subjected to in your life. These can affect your current spinal, nerve and health status. The physical, emotional, and chemical stresses may be the cause of **Vertebral Subluxations**.

***I have read the above statement (signature required)*** ______________________________

## FAMILY MEDICAL HISTORY:

Has anything changed in your family's health in the past year for grandparents, parents & siblings? ❑ Yes ❑ No
If yes, explain: ______________________________

## PHYSICAL STRESS:

Have you had any accidents, injuries, hospitalizations or surgeries in the past year? ❑ Yes ❑ No
If yes, explain: ______________________________
Check all that apply to your life currently: ❑ Exercise ❑ Hobbies ❑ Recreational Activities ❑ Active at Work
How do you grade your Physical Health: ❑ Good ❑ Fair ❑ Poor

## EMOTIONAL STRESS:

Do you have stress in your life? ❑ Yes ❑ No
If yes, explain: ______________________________
How do you grade your Mental Health: ❑ Good ❑ Fair ❑ Poor
How do you grade your Emotional Health: ❑ Good ❑ Fair ❑ Poor
How do you grade your Social Health: ❑ Good ❑ Fair ❑ Poor

## CHEMICAL STRESS:

Vaccination in the past year? ❑ Yes ❑ No If yes, which ones: ______________________________
Developed any food or medication allergies in the past year? ❑ Yes ❑ No
If yes, explain: ______________________________
Diet Includes (check all that apply): ❑ Homemade Food ❑ Processed Food ❑ Diet Food Products ❑ Fast Food

**Note: It is imperative that you list all medications as they may have an influence on your care.**

| Medication (OTC/Rx) or SUPPLEMENT | Dosage | Frequency | Method | Reason for Taking |
|---|---|---|---|---|
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Have you been exposed to any of the following on a regular basis in the past year?

❑ Mold ❑ Perfume ❑ Scented Candles ❑ Air Freshener/Plug-ins ❑ Drug Therapy
❑ Lotions ❑ Bleach ❑ Beauty Products ❑ Household Cleaning Products ❑ Plastic Use
❑ Antibiotic Use ❑ Nursed ❑ Formula Fed ❑ Recreational Drugs ❑ Dryer Sheets
❑ Tobacco Use ❑ Radiation ❑ Smoke ❑ Secondhand Smoke ❑ Alcohol Use
❑ Caffeine ❑ Soda ❑ Coffee ❑ Chemicals at work ❑ Other

| Exposure | Frequency | Amount | Exposure | Frequency | Amount |
|---|---|---|---|---|---|
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Patient Name: ______________________________

# Updated Health History Cont.

**REVIEW OF SYSTEMS:** Check ❑C for CURRENT symptoms and ❑H for symptoms you've had a HISTORY of.

**MANY OF THESE CONDITIONS RESPOND TO CHIROPRACTIC AND ACUPUNCTURE TREATMENT**

**GENERAL/MIND/STRESS:**
❑C ❑H Recent Weight Change
❑C ❑H Fever
❑C ❑H Fatigue
❑C ❑H Cancer
❑C ❑H Eating Disorder
❑C ❑H Alcoholism
❑C ❑H Nervousness
❑C ❑H Depression
❑C ❑H Sleep Problems
❑C ❑H Memory Loss
❑ *NONE IN CATEGORY*

**MUSCULOSKELETAL:**
❑C ❑H Low Back Pain
❑C ❑H Mid Back Pain
❑C ❑H Neck Pain
❑C ❑H Arm Problems
❑C ❑H Leg Problems
❑C ❑H Painful Joints
❑C ❑H Stiff/Swollen Joints
❑C ❑H Sore/Weak Muscles or Joints
❑C ❑H Muscle Spasms or Cramps
❑C ❑H Sciatica
❑C ❑H Scoliosis
❑ *NONE IN CATEGORY*

**NEUROLOGICAL:**
❑C ❑H Numbness or Tingling Sensation
❑C ❑H Loss of Feeling
❑C ❑H Dizziness or Light Headed
❑C ❑H Headaches
❑C ❑H Convulsions or Seizures
❑C ❑H Tremors
❑C ❑H Stroke
❑ *NONE IN CATEGORY*

**GENITOURINARY:**
❑C ❑H Sexual Difficulty
❑C ❑H Venereal Disease
❑C ❑H Kidney Stones
❑C ❑H Burning/Painful Urination
❑C ❑H Change of Urination force/strain
❑C ❑H Blood in Urine
❑C ❑H Prostrate Trouble
❑ *NONE IN CATEGORY*

**GASTROINTESTINAL:**
❑C ❑H Loss of Appetite
❑C ❑H Ulcers
❑C ❑H Digestion Problems
❑C ❑H Constipation
❑C ❑H Diarrhea
❑C ❑H Abdominal Pain
❑C ❑H Blood in Stool
❑C ❑H Change in Bowel Movements
❑C ❑H Painful Bowel Movements
❑C ❑H Nausea or Vomiting
❑ *NONE IN CATEGORY*

**CARDIOVASCULAR & HEART:**
❑C ❑H Pacemaker
❑C ❑H Irregular Heartbeat
❑C ❑H Rapid Heartbeat
❑C ❑H Chest Pains
❑C ❑H Swelling of Hands, Ankles, Feet
❑C ❑H Heart Problems
❑C ❑H Arteriosclerosis
❑ *NONE IN CATEGORY*

**RESPIRATORY:**
❑C ❑H Difficulty Breathing
❑C ❑H Persistent Cough
❑C ❑H Coughing Blood
❑C ❑H Asthma or Wheezing
❑C ❑H Lung Problems
❑C ❑H Tuberculosis
❑C ❑H Bronchitis
❑C ❑H Shortness of Breath
❑ *NONE IN CATEGORY*

**EYES & VISION:**
❑C ❑H Contacts or Glasses
❑C ❑H Blurred or Double Vision
❑C ❑H Eye Pain
❑C ❑H Glaucoma
❑C ❑H Eye disease or Injury
❑ *NONE IN CATEGORY*

**SKIN AND BREASTS:**
❑C ❑H Rash or Itching
❑C ❑H Change in Hair or Nails
❑C ❑H Breast Pain, Lump, Discharge
❑ *NONE IN CATEGORY*

**EARS, NOSE, THROAT:**
❑C ❑H Bleeding Gums / Mouth Sores
❑C ❑H Bad Breath or Bad Taste
❑C ❑H Dental problems
❑C ❑H Swollen Throat
❑C ❑H Voice Change
❑C ❑H Swollen Glands in Neck
❑C ❑H Ringing in Ears
❑C ❑H Ear Ache
❑C ❑H Sinus Problems
❑C ❑H Allergies
❑C ❑H Nose Bleeds
❑C ❑H Loss of Smell
❑C ❑H Hearing Loss
❑ *NONE IN CATEGORY*

**ENDOCRINE, BLOOD, LYMPH:**
❑C ❑H Thyroid problems
❑C ❑H Diabetes
❑C ❑H Excessive Thirst / Urination
❑C ❑H Cold Extremities
❑C ❑H Heat or Cold Intolerance
❑C ❑H Change in Hat or Glove Size
❑C ❑H Dry Skin
❑C ❑H Glandular or Hormone Problem
❑C ❑H Swollen Glands
❑C ❑H Anemia
❑C ❑H Varicose Veins
❑C ❑H Bruise or Bleed Easily
❑C ❑H Phlebitis
❑C ❑H Transfusion
❑C ❑H Immune System Disorder
❑ *NONE IN CATEGORY*

**WOMEN ONLY:**
Last Period ___________________
❑C ❑H Infertility
❑C ❑H Excessive Menstruation
❑C ❑H Cramps/Painful Periods
❑C ❑H Irregular Periods
❑C ❑H Vaginal Discharge
❑ *NONE IN CATEGORY*

| ***Pregnancies:*** | |
|---|---|
| Date | Outcome |
| | |
| | |
| | |
| | |

How do you grade your over all "Quality of Life" ❑ Good ❑ Fair ❑ Poor

How much water do you consume on a daily basis (in ounces):_____________

*More information regarding the above marked symptoms:* ____________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________

*I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize RCC to provide me with chiropractic care, diagnostic testing, and/or therapeutic services, in accordance to Kansas' statutes.*

Patient or Guardian Signature ______________________________________________________ Date ____________

Treating Doctor Signature _________________________________________________________ Date ____________

***Thank you for choosing River City Chiropractic. We look forward to helping you!***

Patient Name: __________________________

# Updated Health History Cont.

Patient Name: ___________________________