NOBLE CHOICE CHIROPRACTIC

CONFIDENTIAL PATIENT HISTORY

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Patient _____ Date: _____ Height: _____

Weight: _____ Referred by: _____

Major complaint and symptoms: _____

How do you believe your problem (pain) began? _____

When did you first notice this problem/pain?_____

Which positions or activities aggravate your condition? _____

Which positions or activities relieve your condition? _____

Have you ever been treated by any other physicians for this ailment? Yes / No

If yes, where? _____

Diagnosis of previous physician _____

Length of time under care _____ Results _____

General Health Questionnaire

Do you have vertigo (dizziness)?.....Yes / No

Do you pass out easily (faint or loss of consciousness)? .....Yes / No

Do you have double vision or have you lost sight in one eye? .....Yes / No

Do you have any slurred speech or difficulty with speech? .....Yes / No

Do you have indigestion or difficulty swallowing? .....Yes / No

Do you have any difficulty walking, with coordination or falling to one side? .....Yes / No

Do you have nausea or vomiting? .....Yes / No

Do you have numbness on one side of your face or body? .....Yes / No

Do you have any visual disturbances or rapid eye movement? .....Yes / No

Do you have or have you ever had difficulty in arranging words properly? .....Yes / No

Do you have a headache or head pain that is unlike any you have had before? .....Yes / No

Do you have headaches for hours or days? .....Yes / No

Do you have a history of stroke in your family? .....Yes / No

Do you have chest pain? .....Yes / No

Do you have a sore that does not heal? .....Yes / No

Do you have any unusual bleeding or discharge? .....Yes / No

Do you have a nagging cough or hoarseness? .....Yes / No

Do you have night sweats? .....Yes / No

Do you have pain in the neck, jaw or face? .....Yes / No

Do you have a drooping eyelid or change in your pupils? .....Yes / No

Do you have any ringing in your ears? .....Yes / No

Have you ever had cancer? .....Yes / No

Does your pain ever wake you from a sound sleep? .....Yes / No

Are you losing any weight now without trying? .....Yes / No

Have you had any loss of bladder or bowel control? .....Yes / No

Have you lost consciousness or had double vision recently? .....Yes / No

Do you take birth control pills? .....Yes / No

Are you taking any prescription medications? .....Yes / No

If yes, please list _____

Are you taking herbs, supplements, botanicals, or vitamins? .....Yes / No

If yes, please list _____

Are you taking any medication or over-the-counter drugs? (aspirin, etc.).....Yes / No

If yes, Please list _____

Are you seeing any other doctor now for any reason? .....Yes / No

If yes, please explain _____

(Women only) Do you have any reason to believe that you may be pregnant? .....Yes / No

What operations have you had? Please include cosmetic surgery, breast implants, etc.

_____ Year _____

_____ Year _____

SOCIAL HISTORY

Smoker?.....Yes / No If yes, how many packs a day? _____ Years? _____

Alcohol?.....Yes / No If yes, how much? _____ Years? _____

FAMILY HISTORY

Did your mother or father have any of the following: Put an **M** for mother, **F** for father, and **B** for both.

___ High Blood Pressure

___ Heart Attack

___ Emphysema

___ Seizure/Convulsions

___ HIV Positive

___ Asthma

___ Diabetes

___ Kidney Disease

___ Ulcer or Stomach Problems

___ Stroke (Please indicate age when stroke occurred)

Mother___ Father ___

___ Arthritis

___ Mental Illness

___ Thyroid Disease

___ Circulation Problems

___ Cancer

Are you currently being treated or have you ever been treated for ANY condition not listed above? Please list the conditions and treatment: _____

Patient signature:_____ **Date:** _____