

**Needham Family Chiropractic**  
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**CONFIDENTIAL HEALTH INFORMATION**

DATE: \_\_\_\_\_ REFERRED BY: \_\_\_\_\_  
Name: \_\_\_\_\_ SS# \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Marital Status: S M D W L/W  
Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  
Business Address: \_\_\_\_\_ Business Phone: \_\_\_\_\_  
Name of Spouse: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Ages of Children: \_\_\_\_\_  
Nearest Relative (not living with you): \_\_\_\_\_

**PRESENT HEALTH STATUS:**

Reason for consulting this office (please be specific):  
\_\_\_\_\_

**If a major complaint or problem is present, please answer these questions:**

When did it start? \_\_\_\_\_

Describe what you are feeling? \_\_\_\_\_

Have you ever had this condition before? \_\_\_\_\_

Is this condition getting: \_\_\_ progressively worse, \_\_\_ constant, \_\_\_ comes & goes, \_\_\_ better

Is this condition interfering with your: \_\_\_ work, \_\_\_ sleep, \_\_\_ daily routine, \_\_\_ other.

If "other" please explain: \_\_\_\_\_

What do you believe is wrong with you? \_\_\_\_\_

Have you consulted other doctors or health professionals for this problem? \_\_\_\_\_

If so, whom? \_\_\_\_\_

What significant health problems have you had in the past? \_\_\_\_\_

What accidents, falls or injuries (even minor ones) have you had? Note: This includes childhood falls, contact sports etc. \_\_\_\_\_

Have you ever broken or fractured any bones? \_\_\_ Yes \_\_\_ No

Describe how it occurred. \_\_\_\_\_

What surgeries or operations have you had? (indicate dates) \_\_\_\_\_

Drugs or medications you currently take: \_\_\_ Tranquilizers \_\_\_ Pain Killers \_\_\_ Muscle Relaxants  
\_\_\_ Pep Pills \_\_\_ Birth Control Pills

Others (please list) \_\_\_\_\_

HABITS:	HEAVY	MODERATE	LIGHT	NONE
Alcohol	_____	_____	_____	_____
Coffee	_____	_____	_____	_____
Tobacco	_____	_____	_____	_____
Drugs	_____	_____	_____	_____
Exercise	_____	_____	_____	_____
Sleep	_____	_____	_____	_____
Appetite	_____	_____	_____	_____

**REVIEW OF SYMPTOMS**

Do you now, or have you ever experienced any of the following on a regular basis:  
 (Place N if now; P if ever in the past; NP if both now and in the past. Example: NP Allergy)

- |   |  |   |  |
|---|--|---|--|
| <input type="checkbox"/> Allergy          | <input type="checkbox"/> Poor Posture        | <input type="checkbox"/> Tonsillitis      | <input type="checkbox"/> Jaundice          |
| <input type="checkbox"/> Dizziness        | <input type="checkbox"/> Sciatica            | <input type="checkbox"/> Tuberculosis     | <input type="checkbox"/> Itching           |
| <input type="checkbox"/> Fatigue          | <input type="checkbox"/> Spinal Curvatures   | <input type="checkbox"/> Bruise Easily    | <input type="checkbox"/> Varicose Veins    |
| <input type="checkbox"/> Headache         | <input type="checkbox"/> Swollen Joints      | <input type="checkbox"/> Hay Fever        | <input type="checkbox"/> Bed-Wetting       |
| <input type="checkbox"/> Loss of Sleep    | <input type="checkbox"/> Colon Trouble       | <input type="checkbox"/> Nosebleeds       | <input type="checkbox"/> Blood in Urine    |
| <input type="checkbox"/> Ulcers           | <input type="checkbox"/> Diarrhea            | <input type="checkbox"/> Sinus Infection  | <input type="checkbox"/> Painful Urination |
| <input type="checkbox"/> Nerv/Depress     | <input type="checkbox"/> Difficult Digestion | <input type="checkbox"/> Hi Blood Press   | <input type="checkbox"/> Freq. Urination   |
| <input type="checkbox"/> Numbness         | <input type="checkbox"/> Hemorrhoids         | <input type="checkbox"/> Lo Blood Press   | <input type="checkbox"/> Arthritis         |
| <input type="checkbox"/> Kidney Inf/stone | <input type="checkbox"/> Nausea              | <input type="checkbox"/> Pain Over Heart  | <input type="checkbox"/> Prostate Trouble  |
| <input type="checkbox"/> Bursitis         | <input type="checkbox"/> Asthma              | <input type="checkbox"/> Poor Circulation | <input type="checkbox"/> Cramps/backache   |
| <input type="checkbox"/> Foot Trouble     | <input type="checkbox"/> Colds               | <input type="checkbox"/> Rapid Heart Beat | <input type="checkbox"/> Alcoholism        |
| <input type="checkbox"/> Low Back Pain    | <input type="checkbox"/> Deafness            | <input type="checkbox"/> Slow Heart Beat  | <input type="checkbox"/> Diabetes          |
| <input type="checkbox"/> Neck Pain/Stiff  | <input type="checkbox"/> Ear Infections      | <input type="checkbox"/> Anemia           | <input type="checkbox"/> Polio             |
| <input type="checkbox"/> Ear Noises       | <input type="checkbox"/> Stroke              | <input type="checkbox"/> Swelling Ankles  | <input type="checkbox"/> Cancer            |
| <input type="checkbox"/> Chest Pain       | <input type="checkbox"/> Enlarges Thyroid    | <input type="checkbox"/> Pleurisy         | <input type="checkbox"/> Epilepsy          |
| <input type="checkbox"/> Eye Pain         | <input type="checkbox"/> Difficult Breathing | <input type="checkbox"/> Failing Vision   | <input type="checkbox"/> Hepatitis         |
| <input type="checkbox"/> Spitting         | <input type="checkbox"/> Venereal Disease    | <input type="checkbox"/> Blurred Vision   |  |

Tingling/Numbness in:

- Shoulders    Hips    Arms    Legs    Elbows    Knees    Hands    Feet

**FOR WOMEN:**

- Did you experience back labor or excessively painful labor?    Yes    No  
 Did you experience a lengthy or difficult labor?    Yes    No  
 Are you, or may you be pregnant?    Yes    No

**FOR CHILDREN:**

- Any complications during pregnancy or birth?    Yes    No  
 If yes, describe: \_\_\_\_\_

Type of birth?    Natural    Caesarean    Forceps    Other

- Any complications after birth?    Yes    No

Describe: \_\_\_\_\_