



Showers Chiropractic and Acupuncture Clinic

Patient: _____

Date: _____

Past Health History

- In general, would you say your health is (circle one): Excellent Very good Good Fair Poor
- Have you ever had a stroke or issues with blood clotting? Y N If Yes, When _____
- Have you recently experienced dizziness, unexplained fatigue, weight loss or blood loss? Y or N
If Yes, explain: _____
- Have you ever had any major illnesses, injuries, broken bones, hospitalizations or surgeries? Y or N

Date	Injury/Fracture/Illness/Surgeries	Treatment	Results

Systems Review Questions

Do you now or have you ever had any problems with the following areas? If so, mark the problems with an X.

- | | | | |
|----------------------------------|-------------------------|--------------------------|----------------------------------|
| _____ Eyes, Ears, Nose | _____ Muscles | _____ Weakness | _____ Allergies |
| _____ Mouth, Throat | _____ Nerves | _____ Cancer | _____ Psychological/Emotional |
| _____ Headaches | _____ Numbness/Tingling | _____ Thyroid | Females only: |
| _____ Heart, Chest Pain, High BP | _____ Joints/Bones | _____ Liver | _____ Gynecological/Menstrual |
| _____ Lungs/Breathing | _____ Skin | _____ Gall Bladder | _____ Breast |
| _____ Stomach/Intestines/Bowels | _____ Internal Organs | _____ Bone density | Male Only: |
| _____ Urinary Problems | _____ Blood | _____ Sinus problems | _____ Prostate/Testicular/Penile |
| _____ Weight loss/gain | _____ Diabetes | _____ Fainting/Dizziness | |

Do you think you may be pregnant? Y or N If yes, how far along? _____
Other _____

Medications

List current medications: _____

Social History and Family History

- | | | | | | | | |
|--|---------------------|---|---|-----|-----|-----|-----|
| Do you exercise? Y or N _____ times per week | Diabetes | M | F | MGM | MGF | PGM | PGF |
| Do you consume alcohol? Y or N _____ drinks per week | Thyroid ds | M | F | MGM | MGF | PGM | PGF |
| Do you get adequate sleep? Y or N _____ | Cancer | M | F | MGM | MGF | PGM | PGF |
| Is work stressful to you? Y or N _____ | Heart ds | M | F | MGM | MGF | PGM | PGF |
| Is family life stressful to you? Y or N _____ | Lung ds | M | F | MGM | MGF | PGM | PGF |
| Do you use recreational drugs? Y or N _____ | Arthritis | M | F | MGM | MGF | PGM | PGF |
| Do you smoke? Y or N _____ packs per day | Seizure/Stroke | M | F | MGM | MGF | PGM | PGF |
| Do you consume caffeine Y or N _____ | High Blood pressure | M | F | MGM | MGF | PGM | PGF |

Chiropractic History

- Have you ever been to a chiropractor before? YES NO
- How long have you been under chiropractic care? _____
- Did you get good results from your previous chiropractor? _____
- How long has it been since your last adjustment? _____
- What conditions was your previous chiropractor treating? _____