EASTMAN-KINGREY CLINIC
WESTLAKE, LA

CONFIDENTIAL HEALTH HISTORY

Date:_____ File:_____

PERSONAL

Name: _____ Sex: M/F Age:_____Date of Birth:_____
Phone (home):_____(cell):_____ (work): _____
What do you prefer to be called?: _____SS#: _____Height:_____ Weight: _____Marital Status: Single__Married__ Divorced__ Widowed__ Number of children:_____
Address: _____ City:_____ State:_____ Zip: _____
Employer: _____ How long?: _____ Employer Address:_____
Occupation: _____ How long?: _____
Spouse: _____ Spouse's employer: _____
Referred by: _____ In case of emergency notify: _____
Preferred Language: _____E-mail: _____

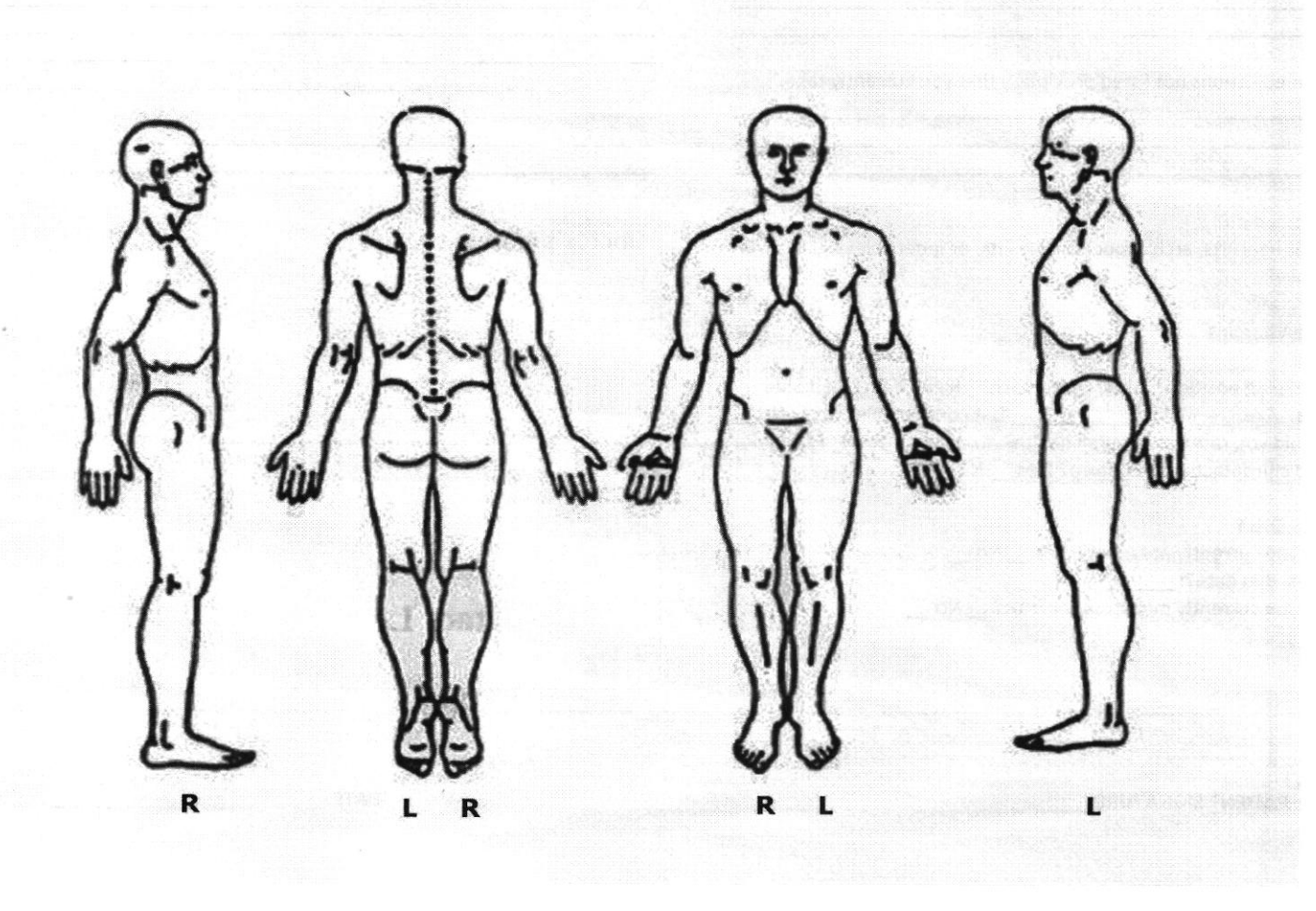
CURRENT CONDITION

Please describe the principal health problems for which you came to this office: _____
_____
How and when did symptoms first occur?: _____
List any other doctors seen for these problems: _____
List any diagnosis(es) and type of treatment: _____

Are you taking any medications for the current condition?: Yes__ No__ Have they helped?: A lot__ Some__ Not at all __
Type of medications?: Pain killers__ Muscle relaxers__ Anti-inflammatory__ Other_____
Have you lost any days of work?: Yes__ No__ Dates:_____
Have you had similar symptoms before?: Yes__ No__ When?:_____

Check if you currently have or recently had any of the following:
Trauma____ Fever____ Infection____ Weight loss____ Loss of bladder control____ None____

SHOW US WHERE IT HURTS. CIRCLE AREAS ON THE BODY THAT BROUGHT YOU IN TODAY!



HEALTH HISTORY

Check the following conditions/procedures you have/had:

__Anemia
__Cancer
__ Diabetes
__ Epilepsy
__ Fibromyalgia
__Gout
__Hepatitis
__HIV/AIDS
__Lupus
__ Multiple Sclerosis
__Osteoporosis
__ Rheumatoid Arthritis
__ Thyroid Condition
__ Urinary Tract Infections
__Venereal Disease
__Asthma
__Emphysema
__Tuberculosis
__Artificial Joints
__ Bone Fracture
__ Bone Fusion
__ Disc Herniation
__Dislocations
__Hernia
__Sciatica
__Scoliosis
__Tendon/Ligament Rupture
__ TMI Condition
__ Whiplash
__Arteriosclerosis
__ Cardiovascular Disease
__ Heart Attack/Stroke
__ Heart Defect
__Heart Murmur
__High Blood Pressure
__Low Blood Pressure
__Pacemaker
__Colitis
__ Gallbladder Condition
__ Gastric Reflux
__ Hemorrhoids
__Kidney Condition
__ Liver Condition
__Rectal Polyps
__ Ulcers
__Endometriosis
__ Hormone Replacement
__ Ovarian/Uterine Cyst
__Prostate Condition
__Testicle Condition

Please Circle the appropriate letter for any of the following symptoms:

O-OCCASIONAL
F- FREQUENT
C-CONSTANT

O F C- Severe/frequent Headaches
O F C- Jaw Pain
O F C- Eye Problems
O F C- Sinus Problems
O F C- Ear Problems
O F C- Nose Bleeding
O F C- Nose Discharge
O F C- Sore Throat
O F C- Dental Problems
O F C- Swollen Lymph Nodes

GENITOURINARY
O F C- Bladder Trouble
O F C- Excessive Urine
O F C- Painful Urination
O F C- Discolored Urine
O F C- Urinary Infection

RESPIRATORY
O F C- Difficulty Breathing
O F C- Coughing Blood
O F C- Coughing Phlegm
O F C- Chest Pain

CARDIOVASCULAR
O F C- Pain over Heart
O F C- Rapid Heartbeat

GASTROINTESTINAL
O F C- Weight Trouble
O F C- Excessive Thirst
O F C- Excessive Hunger
O F C- Poor Appetite
O F C- Heartburn
O F C- Abdominal Pain
O F C- Nausea/Vomiting
O F C- Diarrhea
O F C- Constipation
O F C- Black Stool
O F C- Bloody Stool

MUSCULOSKELETAL
O F C- Back Pain
O F C- Neck Pain
O F C- Pain Between Shoulders

PAIN OR NUMBNESS IN :
O F C- Shoulders
O F C- Arms
O F C- Elbows
O F C- Hands
O F C- Hips
O F C- Legs
O F C- Knees
O F C- Feet
O F C- Swollen/Stiff Joints
O F C- Loss of Strength
O F C- Walking Problems

NERVOUS
O F C- Seizures
O F C- Fainting
O F C- Dizziness
O F C- Paralysis
O F C- Loss of Feeling

FEMALES ONLY:
O F C- Vaginal Discharge
O F C- Irregular Vaginal Bleeding
O F C- Vaginal Pain
O F C- Breast Pain
O F C- Breast Lumps
O F C- Hot Flashes

Please Answer

List any health conditions within the last year:

_____
_____
_____

List any medications not listed previously that you currently take:

_____
_____
_____

List approximate date of any other operations, diseases, serious illnesses or accidents you have had:

_____
_____
_____
_____
_____
_____
_____
_____

DO YOU:

Wear heel lifts, arch supports, sole lifts, or inner soles? Y/N
Smoke? Y/N
Exercise? Y/N
Take Vitamins? Y/N

Allergies: _____
Usual sleeping position? Back__ Stomach__ Right Side__ Left Side __
Mattress: Age: ___ Type: _____ Is it comfortable: Yes__ No __
How would you rate your overall health?: Excellent_ Good_ Fair_ Poor_
Received chiropractic care before?: Yes __ No __

FEMALES ONLY

Are you currently pregnant?: Yes __ No __
If yes, due date?: _____
Are you currently menstruating?: Yes __ No __

Doctor's Notes:

PATIENT SIGNATURE: _____ **DATE:** _____