Sports & Spinal Injury Clinic, LLC
Health History Form

NAME: ________________________ID#: _____ DOB: __________ M / F DATE: __________

Please check any of the following you have or have had.

❑ Alcohol / Drug Abuse
❑ Anemia
❑ Arthritis
❑ Artificial Bones / Joints
❑ Artificial Valves
❑ Asthma / Difficulty Breathing
❑ Cancer
❑ Chemotherapy
❑ Congenital Heart Defect
❑ Diabetes / Tuberculosis
❑ Disc Herniation _____________
❑ Emphysema / Lung Disorder
❑ Fainting / Seizures / Epilepsy
❑ Fibromyalgia
❑ Frequent Neck Pain
❑ Frequent / Severe Headaches
❑ Glaucoma
❑ Heart Attack
❑ Heart Murmur
❑ Heart Surgery / Pacemaker
❑ Hepatitis
❑ High / Low Blood Pressure
❑ HIV+ / Aids
❑ Kidney Problems
❑ Lower Back Pain
❑ Lupus
❑ Mitral Valve Prolapse
❑ Psychiatric Problems
❑ Rheumatic Fever
❑ Scoliosis
❑ Shingles
❑ Sinus Problems
❑ Stroke
❑ Ulcers / Colitis
❑ Venereal Disease
❑ Other _________________

Please list any medications (prescriptions and non-prescriptions) you are currently taking.: ____________________
____
Please list any other serious medical condition(s) you have or ever had: ____________________________________
____
Please list anything that you may be allergic to: ____
____
List previous surgeries/treatments with dates: ____
____
List any **past** serious accidents/injuries/illnesses with dates: ____
____
List any fractures/broken bones: ____
____
Family Health History: ____
____
Other complaints: ____
____
Do you smoke/chew tobacco? If so, how much? ________________ How long? ________________
Do you drink alcohol / drugs? If so, how much? ________________ How long? ________________
Do you consume caffeine on a regular basis? ❑ Yes ❑ No / How much? ___________________
Describe your dietary habits: ____
____
Are you wearing: ❑ Heel Lifts ❑ Sole Lifts ❑ Inner Soles ❑ Arch Supports
Is your mattress supportive? ❑ Yes ❑ No Do you exercise?: ❑ Rarely ❑ Frequently ❑ Routinely
Do you sleep on your ❑ Back ❑ Left side ❑ Right side ❑ Stomach
What types of exercise do you do? ____
____
Any other relative information: ____
Have you ever been treated by a Chiropractor before? ❑ Yes ❑ No

For women: Pregnant? ❑ Yes ❑ No / How long? __________ Nursing? ❑ Yes ❑ No
Birth Control? ❑ Yes ❑ No If so, what? ____________________