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 far along? _____ Nursing? ❑ Yes ❑ No
Birth Control? ❑ Yes ❑ No If so, what? _____