Last________________________First____________________________DOB____________Date_____________

HEALTH HISTORY

(Page 1 of 2)

PERFORMANCE CHIROPRACTIC CLINIC

16030 Bothell-Everett Hwy, Suite 220 Mill Creek, WA 98012
Phone: 425-385-3060, Fax: 425-385-2230

When was your last complete physical? Date ___________	NO	YES	If yes, explain	Doctor's Use Only
Was your blood or urine tested?	☐	☐		
Did your doctor find anything unusual or abnormal?	☐	☐		
Do you have an ongoing or chronic illness?	☐	☐		
Were you born with any anomalies (cleft palate, spina bifida, etc)?	☐	☐		
Are you currently under care for any condition?	☐	☐		
Do you take any over the counter drugs for pain or allergies?	☐	☐		
Are you allergic to any medications, foods or insect bites?	☐	☐		
If yes do you carry an epipen?	☐	☐		
Have you ever spent a night in the hospital other than for surgery?	☐	☐		
Have you ever fractured a bone?	☐	☐		
Did you ever separate or dislocate a joint?	☐	☐		
Have you ever had a sprain or strain that kept you from your normal activities for more than 3 days?	☐	☐		
Have you ever had any spinal x-rays?	☐	☐		
Have you ever had an MRI, EMG or other diagnostic test?	☐	☐		
Have you ever had any surgeries (tonsils, appendix, etc)?	☐	☐		
Have you had any loss of appetite recently? Have you noticed any recent weight gain or weight loss?	☐	☐		
If yes, was it voluntary?	☐	☐		
Do you have difficulty sleeping?	☐	☐		
Do you average less than 6 hours of sleep per night?	☐	☐		
Do you ever have to take sleeping aids (Tylenol PM, Marijuana, Ambien, Alcohol, etc…)?	☐	☐		
Have you ever or do you currently smoke?	☐	☐		
Do you drink alcohol?	☐	☐		
Do you drink coffee or tea?	☐	☐		
Do you drink 8 glasses of water a day?	☐	☐		
What was your weight at age 18? ___________				
Do you take any herbs, vitamins or nutritional supplements?	☐	☐		
Are you on a special diet or nutritional program?	☐	☐		
Do you eat less than 3 meals a day?	☐	☐		
Do you currently eat 8-10 servings of fruits/vegetables per day?	☐	☐		
Would you be interested in learning how your diet could be affecting your condition/pain and how certain dietary changes or supplements could help?	☐	☐		
Do you do cardiovascular exercises weekly?	☐	☐		
Do you do weight training weekly?	☐	☐		
Do you stretch daily?	☐	☐		
Do you currently compete in a sport?	☐	☐		
Do you have an upcoming scheduled event you are planning to compete in?	☐	☐		
Do you wear foot orthotics or require special protective or corrective device for your sport?	☐	☐		
Does your job require hard Physical Labor?	☐	☐		
Have you ever had a work related injury?	☐	☐		
Is your station ergonomically set-up at work?	☐	☐		

Are you currently taking any medications? (circle one) Yes No

If Yes, please list names of medication and the condition it was prescribed for ______________________________

____

____

Please complete both sides of form

Last_________________________First____________________________DOB____________Date_____________

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	NO	YES	If yes, explain	Doctor's Use Only
Do you have vertigo (dizziness)?	☐	☐		
Do you pass out easily (faint or loss of consciousness)?	☐	☐		
Do you have double vision, loss of sight in one eye, or any other visual disturbances?	☐	☐		
Do you have any slurred speech or difficulty with speech?	☐	☐		
Do you have indigestion or difficulty swallowing?	☐	☐		
Do you have any difficulty walking, with coordination, or falling?	☐	☐		
Do you have any nausea or vomiting?	☐	☐		
Do you have numbness on one side of your face or body?	☐	☐		
Have you recently experienced a headache unlike any you have had before?	☐	☐		
Do you have a history of stroke in your family?	☐	☐		
Do you have chest pain?	☐	☐		
Have you noticed any changes in bowel or bladder habits?	☐	☐		
Have you noticed any blood in your urine, stool, or phlegm?	☐	☐		
Do you have any unusual bleeding or discharge?	☐	☐		
Do you wake up in the middle of the night with pains?	☐	☐		
Do you have night sweats?	☐	☐		
Do you have pain when coughing, sneezing or bearing down?	☐	☐		
Do you have any ringing in your ears?	☐	☐		
Do you take birth control pills?	☐	☐		
blood pressure medication?	☐	☐		
blood thinners?	☐	☐		

Family History

How many siblings do you have? Brothers_____ Sisters_______
Are your parents still living? Mother (Y) or (N) Father (Y) or (N)
Do you have any children? (Y) or (N) If yes, how many boys? ________ girls?__________

Has anyone in your immediate family experienced any of the following conditions?
(Please use abbreviations as indicated)

M – Mother S – Sister MM – Mothers Mother FM – Fathers Mother
F – Father B – Brother MF – Mothers Father FF – Fathers Father

Y N
High Blood Pressure________________
Seizures___________________________
Diabetes___________________________
Heart Disease______________________
Multiple Sclerosis __________________
Cancer (indicate types)____

Y N
Strokes___________________________
High Cholesterol___________________
Arthritis___________________________
Genetic Disorders__________________

Please complete both sides of form