Health History Form

Please Print:

Name: _____ Date: _____

Address: _____ Tel. res _____

_____ Tel. bus _____

Date of birth: _____ Occupation: _____

Who referred you / how did you hear about me? _____

What is your primary complaint? _____

What is your secondary complaint? _____

- o I give permission for my health history to be collected for the sole purpose of formulating a treatment plan.
- o I give permission for my Massage Therapist to contact me via mail/phone/email (cards, reminder calls etc.)

*I hereby authorize any of the therapists at Dr. Albuquerque's Chiropractic Clinic from whom I accept treatment to have access to this file for professional purposes. All information that I provide will be kept confidential except as required by law. I understand that I will be asked for written authorization before this information can be released outside of the clinic. I have the right to access personal information in my personal file.

* I certify that the information given in this form is correct and accurately reflects my past and current health status. I will notify the therapist of any changes that occur as soon as possible.

*I agree to provide 24 hours notice to change or cancel my appointment or I will be charged the full appointment fee.

Date: _____ **Signature: _____**

Update 1: _____ Update 2: _____ Update 3: _____ Update 4: _____

Update 5: _____ Update 6: _____ Update 7: _____ Update 8: _____

Health History : Please indicate which conditions you are experiencing, or have experienced:

Respiratory

- o Chronic cough
- o Shortness of breath
- o Bronchitis
- o Asthma
- o Emphysema

Is there a family history of any of the above? Yes No

Cardiovascular

- o High blood pressure
- o Low blood pressure
- o CCHF(chronic congestive heart failure)
- o Heart attack
- o Phlebitis / varicose veins
- o Stroke / CVA
- o Pacemaker or similar device
- o Heart Disease

Is there a family history of any of the above Yes No

Skin

- o Skin conditions: _____

Other Conditions

- o Loss of sensation_____
- o Diabetes (onset:_____)
- o Allergies (i.e. anaphylaxis or skin irritations)_____
- o Epilepsy
- o Cancer, where, what kind? _____
- o Arthritis

Is there a family history of arthritis? Yes No

Head / Neck

- o History of headaches
- o History of migraines
- o Vision problems
- o Vision loss
- o Ear problems
- o Hearing loss

Women

- o Pregnant (due:_____)
- o Gynecological conditions _____

Soft Tissue / joint discomfort and its nature

- o Neck _____
- o Low back _____
- o Mid back_____
- o Upper back _____
- o Shoulders _____
- o Arms _____
- o Legs _____
- o Knees _____
- o Other _____

Infections

- o Hepatitis
- o Skin conditions
- o TB
- o HIV
- o Herpes

Overall how is your general health? _____

Current Medications: _____

Condition it treats: _____

Surgery: _____

Date: _____

Injury: _____

Date: _____

Primary Care physician: _____

Address: _____

Present involvement in other Health care:

- o Yes , specify: _____
- o No

*****See Reverse Side

Other Medical Conditions (e.g. digestive conditions, osteoporosis, mental illness, hemophilia etc.) if so, what?
_____

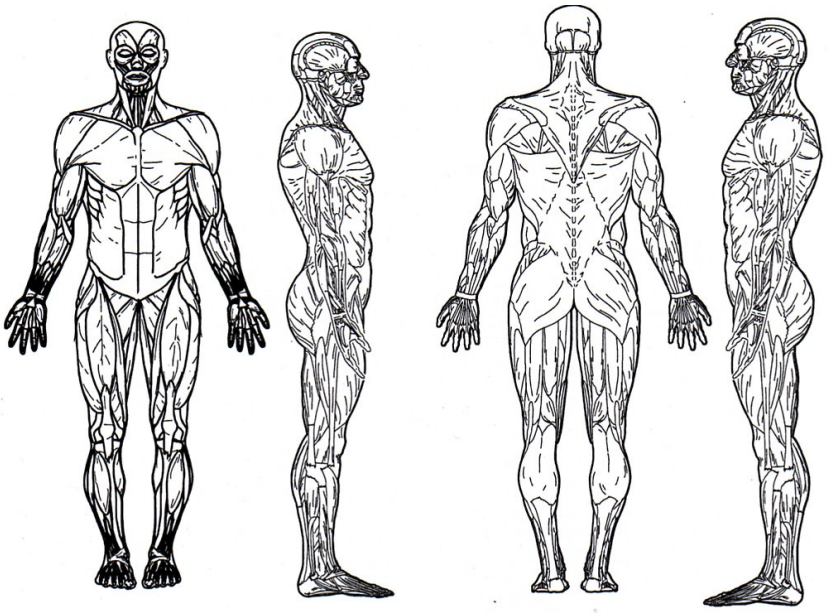
Of Special Note: (internal pins, wires, artificial joints, special equipment) If so, what? Where? _____

Client Consent

I want your informed consent. This means that I want you to understand the services I hope to provide to you, the cost involved, and what I do with the personal information that I obtain from you. If you have any questions, please ask.

PLEASE READ AND SIGN TIS FORM

Please "Circle" specific areas to be treated on the following diagram.
Please mark an "X" on specific areas <u>NOT</u> to be treated on the following diagram.



Signature: _____ Date: _____
(16 years of age or older)

Parental/ Guardian Signature: _____ Date: _____