PROVANCE CHIROPRACTIC
SPORTS AND WELLNESS, LLC

Patient Name_____

Date_____

CONFIDENTIAL HEALTH HISTORY

The items below may relate to your condition. Put a ☐ in the box in front of each item if you have this problem.

GENERAL

- ☐ Fever
- ☐ Chills
- ☐ Night Sweats
- ☐ Loss of Sleep
- ☐ Fatigue
- ☐ Nervousness
- ☐ Weight Loss or Gain
- ☐ Allergies
- ☐ Bleeding Problem
- ☐ Anemia
- ☐ Diabetes
- ☐ Cancer
- ☐ Thyroid Disease/Goiter
- ☐ Alcoholism
- ☐ Drug Abuse
- ☐ Any Surgeries
- ☐ Any Medications-List Below

_____
_____
_____
_____
_____

☐ Any Supplements/Vitamins

_____
_____

- ☐ Any Implanted Medical Devices
- ☐ List any Major Traumas you may have had; Motor Vehicle Accidents, Sports Injuries, Falls, etc.

_____
_____

GASTROINTESTINAL

- ☐ Poor Appetite/Digestion
- ☐ Difficulty Swallowing
- ☐ Belching or Gas
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Vomiting Blood
- ☐ Pain over Abdomen
- ☐ Ulcer
- ☐ Black or Bloody Stool
- ☐ Liver Problems
- ☐ Gall Bladder Problems
- ☐ Jaundice
- ☐ Hernia
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Appendicitis

MEN ONLY

- ☐ Testicular Swelling/Pain
- ☐ Prostate Problems

RESPIRATORY

- ☐ Difficulty Breathing
- ☐ Chronic Cough
- ☐ Spitting Phlegm
- ☐ Spitting Blood
- ☐ Wheezing/Asthma
- ☐ Pneumonia
- ☐ Tuberculosis

CARDIOVASCULAR

- ☐ Irregular Heartbeat
- ☐ High Blood Pressure
- ☐ Pain over Heart
- ☐ Ankle Swelling
- ☐ Varicose Veins
- ☐ Rheumatic Fever
- ☐ Stroke

GENITOUINARY

- ☐ Frequent Urinating
- ☐ Painful Urination
- ☐ Blood in Urine
- ☐ Kidney Disease
- ☐ Inability to Control Urination
- ☐ Difficulty Starting Urine Flow
- ☐ Get Up____Times per night to Urinate
- ☐ Breast Lump or Pain
- ☐ Venereal Infection
- ☐ Sexual Difficulties

WOMEN ONLY

- ☐ Painful Periods
- ☐ Excessive Flow
- ☐ Vaginal Burning or Itching
- ☐ Hot Flashes
- ☐ Date Last Period Began_____
- ☐ Date of Last Pap Test_____

SKIN

- ☐ Itching
- ☐ Burning Easily
- ☐ Change in Mole
- ☐ Skin Cancer

NEUROLOGIC

- ☐ Weakness
- ☐ Twitching
- ☐ Tremors
- ☐ Headache
- ☐ Fainting
- ☐ Dizziness
- ☐ Convulsions
- ☐ Epilepsy
- ☐ Numbness/tingling
- ☐ Arm/Leg Pain
- ☐ Mental Disorder

MUSCULOSKELETAL

- ☐ Neck Stiffness/Pain
- ☐ Pain Between Shoulders
- ☐ Low Back Pain
- ☐ Swollen Joints
- ☐ Painful Joints
- ☐ Muscle Aches/Soreness
- ☐ Spinal Curvature
- ☐ Arthritis
- ☐ Any Fractures

EYE EAR NOSE THROAT

- ☐ Poor Vision
- ☐ Pain in Eyes
- ☐ Deafness/Difficulty Hearing
- ☐ Nose Bleeds
- ☐ Nose Problems
- ☐ Sinus Trouble
- ☐ Dental Problems
- ☐ Hoarseness
- ☐ Tonsillectomy

HABITS

- ☐ Smoking_____Packs per Day
- ☐ Drinking
- ☐ Recreational Drug Use

EXERCISE

- ☐ None
- ☐ 1-2 Times per Week
- ☐ 3-5 Times per Week
- ☐ 6-7 Times per Week

FAMILY HISTORY

- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Kidney Disease
- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Cancer
- ☐ Muscle, Bone, or Nerve Disease

Name

PRIMARY & SECONDARY COMPLAINTS

Date

PRIMARY COMPLAINT

What is your PRIMARY complaint?

When did your PRIMARY complaint start?

What do you believe caused your PRIMARY complaint?

What activity or position makes your PRIMARY complaint worse?

What activity, medication, therapy or position makes your PRIMARY complaint better?

Is your PRIMARY complaint changing? ☑Increasing ☑Decreasing ☑Unchanged

How often do you exerience your PRIMARY complaint? ☑Constantly ☑Intermittently

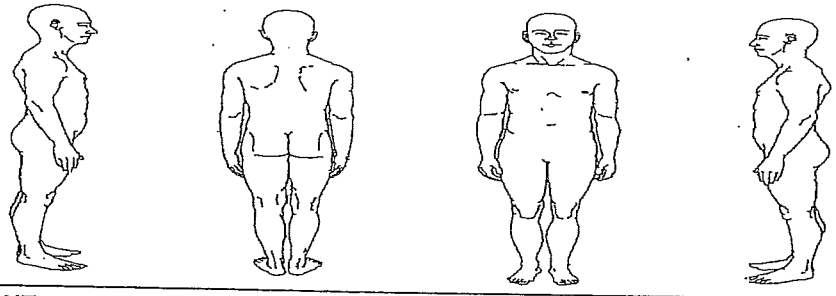
What time of the day is your PRIMARY complaint the worst? ☑Mornings ☑Afternoons ☑Evenings ☑All Day

How does your PRIMARY complaint feel?

☑Sharp ☑Achy ☑Dull ☑Burning ☑Numb ☑Tingling ☑Stiff ☑Pulling ☑Bruised ☑Pulsating ☐Throbbing ☐Cold ☑Other (describe)

Please rate how painful your PRIMARY complaint is. (Least is 1) ①②③④⑤⑥⑦⑧⑨⑩ (Worst is 10)

Please mark all areas of complaint on the figure



SECONDARY COMPLAINT

What is your SECONDARY complaint?

When did your SECONDARY complaint start?

What do you believe caused your SECONDARY complaint?

What activity or position makes your SECONDARY complaint worse?

What activity, medication, therapy or position makes your SECONDARY complaint better?

Is your SECONDARY complaint changing? ☑Increasing ☑Decreasing ☑Unchanged

How often do you exerience your SECONDARY complaint? ☑Constantly ☑Intermittently

What time of the day is your SECONDARY complaint the worst? ☑Mornings ☑Afternoons ☑Evenings ☑All Day

How does your SECONDARY complaint feel?

☑Sharp ☑Achy ☑Dull ☑Burning ☑Numb ☑Tingling ☑Stiff ☑Pulling ☑Bruised ☑Pulsating ☑Throbbing ☑Cold ☑Other (describe)

Please rate how painful your SECONDARY complaint is. (Least is 1) ①②③④⑤⑥⑦⑧⑨⑩ (Worst is 10)

Have you ever had EITHER complaint before? ☑Yes ☑No If so, what type of care have you had and did it help?