# Health History Form

**Mooney Chiropractic**

**Patient's Name:** ______________________________________________ **Account #:** ______________

**Please check any of the following that apply to you, in the appropriate column. Thank You.**

| Past | Present | |
|---|---|---|
| | | **Headaches/Migraines** |
| | | **Dizziness** |
| | | **Tinnitus (Ear Noises)** |
| | | **Jaw Pain** |
| | | **Difficulty in Swallowing** |
| | | **Chronic Sinusitis** |
| | | **Neck Pain** |
| | | **Shoulder Pain** |
| | | **Pain in Upper Arm/Elbow/Hand** |
| | | **Numbness/Tingling in Arm/Elbow/Hand** |
| | | **Upper/Mid Back Pain** |
| | | **Chronic Cough** |
| | | **Chest Pains** |
| | | **Rapid Heart Beat** |
| | | **Heartburn/indigestion** |
| | | **Abdominal Pain** |
| | | **Low back Pain** |
| | | **Pain in Leg/Hip/Knee/Foot** |
| | | **Numbness/Tingling in Leg/Knee/Foot** |
| | | **Swelling of Joints** (List Locations): |

_______________________________________________

| Past | Present | |
|---|---|---|
| | | **Stiffness of Joints** (List Locations): |

_______________________________________________

| Past | Present | |
|---|---|---|
| | | **Fainting** |
| | | **Convulsions** |
| | | **Muscular In-coordination** |
| | | **Loss of Appetite** |
| | | **Abnormal Weight Gain** |
| | | **Abnormal Weight Loss** |
| | | **Menopausal Symptoms** |
| | | **Painful Urination** |
| | | **Loss of Bladder Control** |
| | | **Frequent Urination** |
| | | **Constipation** |
| | | **Rash/ Dermatitis/ Eczema** |
| | | **Osteoporosis** |
| | | **Depression** |
| | | **Aortic Aneurysm** |
| | | **High Blood Pressure** |
| | | **Angina** |

| Past | Present | |
|---|---|---|
| | | **Heart Attack** |
| | | **Stroke** (date): ________________ |
| | | **Asthma** |
| | | **Cancer** (describe): ________________ |
| | | **Prostate Problems** |
| | | **Anorexia** |
| | | **Emphysema** (chronic lung disorders) |
| | | **Arthritis** |
| | | **Diabetes** |
| | | **Ulcer** |
| | | **Kidney Stones** |
| | | **Bladder Infection** |
| | | **Kidney Disorders** |
| | | **HIV/AIDS** |
| | | **Other:** ________________________ |

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_____________________________________________________

| Past | Present | |
|---|---|---|
| | | **Tobacco Use** |
| | | **Alcohol Use** |
| | | **Corticosteroid Use** |
| | | **Medications** (Please list present medications) |

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| Past | Present | |
|---|---|---|
| | | **Drug or Alcohol Dependence** |
| | | **Pregnancy** (# of Births): __________ |
| | | **Permanent Disability Rating** |

**Please list any past Surgical Procedures:** ______________

_____________________________________________________

_____________________________________________________

**Dominant Hand:** **Left** **Right** **Both**

**Height:** ______________ **Weight:** ____________

**Family History: Please mark the following that apply:**
**Cancer** **Diabetes** **High Blood Pressure**
**Cardiovascular Problems/Stroke**