OptimumHealth
AN INTEGRATIVE APPROACH TO HEALING

HEALTH HISTORY

Patient Name ____ Date______________

What treatment have you already received for your condition?

☐ Medications ☐ Surgery ☐ Physical Therapy ☐ Chiropractic Services ☐ None ☐ Other________________________

Name of the doctor(s) who has (have) treated you for your condition: ______________________________________

Date of Last: Physical Exam ______________ Spinal Exam ______________ Spinal X-Ray ____________ Chest X-Ray ____________

Dental X-Ray ______________ MRI, CT-Scan, Bone Scan ______________ Blood Test ______________ Urine Test ________________

Please check "Yes" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes	**Eating Disorder**	☐ Yes	**Hyperglycemia**	☐ Yes	**Prostate Issues**	☐ Yes
Alcoholism	☐ Yes	**Emphysema**	☐ Yes	**Hypoglycemia**	☐ Yes	**Prosthesis**	☐ Yes
Allergy Shots	☐ Yes	**Epilepsy**	☐ Yes	**Kidney Disease**	☐ Yes	**Psychiatric Care**	☐ Yes
Anemia	☐ Yes	**Fractures**	☐ Yes	**Kidney Stones**	☐ Yes	**Rheumatic Fever**	☐ Yes
Appendicitis	☐ Yes	**Gall Stones**	☐ Yes	**Liver Disease**	☐ Yes	**Skin Disorders**	☐ Yes
Arthritis (Osteo)	☐ Yes	**Glaucoma**	☐ Yes	**Measles**	☐ Yes	**STD**	☐ Yes
Arthritis (Rheumatoid)	☐ Yes	**Goiter**	☐ Yes	**Menopause**	☐ Yes	**Stroke**	☐ Yes
Asthma	☐ Yes	**Gout**	☐ Yes	**Migraines**	☐ Yes	**Suicide Attempt**	☐ Yes
Auto Immune Disorder	☐ Yes	**Headaches**	☐ Yes	**Miscarriage**	☐ Yes	**Thyroid Problem**	☐ Yes
Bleeding Disorder	☐ Yes	**Heart Disease**	☐ Yes	**Mononucleosis**	☐ Yes	**Tonsillitis**	☐ Yes
Breast Lump	☐ Yes	**Hepatitis**	☐ Yes	**Multiple Sclerosis**	☐ Yes	**Tuberculosis**	☐ Yes
Bronchitis	☐ Yes	**Hernia**	☐ Yes	**Mumps**	☐ Yes	**Tumors**	☐ Yes
Cancer	☐ Yes	**Herniated Disk**	☐ Yes	**Osteoporosis**	☐ Yes	**Typhoid Fever**	☐ Yes
Cataracts	☐ Yes	**Herpes**	☐ Yes	**Parkinson's**	☐ Yes	**Ulcer**	☐ Yes
Chemical Dependency	☐ Yes	**High Blood Pressure**	☐ Yes	**Pinched Nerve**	☐ Yes	**Yeast Infections**	☐ Yes
Chicken Pox	☐ Yes	**High Cholesterol**	☐ Yes	**Polio**	☐ Yes	**Other** ________________	
Diabetes (please circle) (Type 1, Type 2)	☐ Yes	**History of Extensive Antibiotic Use**	☐ Yes	**Pneumonia**	☐ Yes		

Are you pregnant? ☐ Yes ☐ No ☐ 1st Trimester ☐ 2nd Trimester ☐ 3rd Trimester Due Date?_______________________

Do you have a pacemaker? ☐ Yes ☐ No

Previous Injuries/Surgeries (Include Date):

Falls ______________________________________ Head Injuries ______________________________________

Surgeries ___________________________________ Broken Bones ______________________________________

List any medications (prescription or non-prescription), vitamins, or supplements you are currently taking. ________________________

____

____

List any allergies (including food) of which you are aware. Were you tested for these allergies? ☐ Yes ☐ No

____

Pharmacy Name______________________________ Pharmacy # (______)_____________

Family Medical History (please include which family member – mother (m), father (f), aunt (a), uncle (u), grandparent (g):

Diabetes ______ Hypoglycemia ______ Food Allergies (please specify) ______ Rheumatoid Arthritis ______ Thyroid ______ Digestive Disorders ________

Heart Disease ______ Hypertension ______ Stroke ______ High Cholesterol ______ Cancer(please specify) ______ Osteoporosis ______ Other _______