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

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 _____