Heiden Chiropractic
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Trempealeau, WI 54661
p 608.534.6090
trempealeaufamilychiro.medicfusion.com

Name: _____

Date: _____

## Health History Form

What is your approximate height? _____ What is your approximate weight? _____ lbs

Have you ever smoked cigars or cigarettes? ☐ Yes ☐ No

Do you still smoke? ☐ Yes ☐ No

How much do you smoke? ☐ Less than one pack per week ☐ 1-2 packs per week

☐ 1 pack every two days ☐ 1 pack per day ☐ More than one pack per day

Do you exercise regularly? ☐ Yes ☐ No

Are you pregnant or trying to get pregnant? _____

Check if you have any implants, screws, plates or other foreign objects in your body. ☐ Yes No

☐ Bullet Wound(s) ☐ Infusion Catheter ☐ Ear Implant ☐ Pacemakers ☐ Eye Implant

☐ Brain Plate(s) ☐ Heart Valve(s) ☐ Shrapnel ☐ Other _____

Musculoskeletal Surgeries (Please list any surgeries) i.e. hip, knee ect.

Please describe: _____ Year(s) of surgery: _____

Please describe: _____ Year(s) of surgery: _____

Please describe: _____ Year(s) of surgery: _____

Organ System Surgeries (Please list any surgeries) i.e. appendix, gallbladder, hysterectomy ect.

Please describe: _____ Year(s) of surgery: _____

Check if a physician has ever diagnosed you with cancer. ☐ Yes ☐ No

Please describe: _____ Year(s) of surgery: _____

Please describe: _____ Year(s) of surgery: _____

Allergies: _____ _____ _____ _____

Medications: _____ _____ _____ _____

(If you have a list with you, we will copy it instead)

Patient Name _____ Date_____

**Check if you currently have or have had in the past any of the following conditions:**

| | Past | Present | | Past | Present |
|---|---|---|---|---|---|
| Headaches | □ | □ | Shoulder pain | □ | □ |
| Neck pain | □ | □ | Mid back pain | □ | □ |
| Low back pain | □ | □ | High blood pressure | □ | □ |
| Wrist pain | □ | □ | Elbow pain | □ | □ |
| Foot/Ankle pain | □ | □ | Arthritis | □ | □ |
| Dizziness | □ | □ | Rheumatoid arthritis | □ | □ |
| Heart attack | □ | □ | Stroke | □ | □ |
| Cancer | □ | □ | Type _____ | | |
| Diabetes | □ | □ | Other_____ | | |

## Chief Complaint Form

Describe the reason for your visit:

_____

_____

_____

**When did your symptoms begin?** (select one)
□ Today □ This week □Within last 3 months □ 3 months to 6 months
□ 6 months to one year □ More than one year

**For Women Only**
Are you pregnant? □ Yes □ No

**Which word describes the frequency of your discomfort?** (select one)
□ Constant □ Intermittent □ Occasional □ Rare

**Which phrases best describe changes in your discomfort during the day?** (select one or more)
□ It is worse in the morning □ It is worse in the afternoon □ It is worse at night
□ It changes with the weather □ It does not change

**What helps relieve your discomfort?** (select one or more)
□Ice □ Heat □Medication □Other (please describe) _____

**What activities are limited by your discomfort?** (select one or more)

□ Bending □ Coughing □ Daily routine □ Driving □ Getting up
□ Lifting □ Pushing □ Sitting □ Standing □ Turning head □ walking □ Working