APOLLO CHIROPRACTIC HEALTH AND WELLNESS, LLC

6911 Taylor Ranch Rd NW, STE C-8, Albuquerque, NM 87120
Phone: (505) 792-3311; email: apollo-chiro@comcast.net

SCREENING PERSONAL HEALTH HISTORY

Patient's Name _____ **DOB** _____ **Age** _____ **Date** _____

Clinician Dr. Eric D. Dahl

All information will be kept strictly confidential. Your responses will help determine if chiropractic treatment will benefit you. Please check the appropriate box of all conditions you currently have or have had.

O = Occasional F = Frequent C = Constant

O F C
Muscle / Joint Symptoms, Pain, and/or Numbness
- ☐ ☐ ☐ Arthritis
- ☐ ☐ ☐ Bursitis
- ☐ ☐ ☐ Leg/Foot trouble
- ☐ ☐ ☐ Arm/hand trouble
- ☐ ☐ ☐ Hernia
- ☐ ☐ ☐ Back pain, stiffness
- ☐ ☐ ☐ Neck pain, stiffness
- ☐ ☐ ☐ Pain between shoulders
- ☐ ☐ ☐ Painful tailbone
- ☐ ☐ ☐ Sciatica
- ☐ ☐ ☐ Swollen joints

General
- ☐ ☐ ☐ Allergy
- ☐ ☐ ☐ Dizziness
- ☐ ☐ ☐ Fainting
- ☐ ☐ ☐ Fatigue
- ☐ ☐ ☐ Fever
- ☐ ☐ ☐ Headache
- ☐ ☐ ☐ Loss of sleep
- ☐ ☐ ☐ Loss of weight
- ☐ ☐ ☐ Nerve Pain/Neuralgia
- ☐ ☐ ☐ Numbness
- ☐ ☐ ☐ Sweats
- ☐ ☐ ☐ Tremors

Cardiovascular
- ☐ ☐ ☐ Hardening of arteries
- ☐ ☐ ☐ High blood pressure
- ☐ ☐ ☐ Low blood pressure
- ☐ ☐ ☐ Pain over heart
- ☐ ☐ ☐ Poor circulation
- ☐ ☐ ☐ Rapid heartbeat
- ☐ ☐ ☐ Slow heartbeat
- ☐ ☐ ☐ Swelling of ankles

O F C
Eye, Ear, Nose and Throat
- ☐ ☐ ☐ Asthma
- ☐ ☐ ☐ Colds
- ☐ ☐ ☐ Earache
- ☐ ☐ ☐ Ear discharge
- ☐ ☐ ☐ Ear noise
- ☐ ☐ ☐ Enlarged glands
- ☐ ☐ ☐ Enlarged thyroid
- ☐ ☐ ☐ Eye pain
- ☐ ☐ ☐ Failing vision
- ☐ ☐ ☐ Hay fever
- ☐ ☐ ☐ Hoarseness
- ☐ ☐ ☐ Nasal obstruction
- ☐ ☐ ☐ Near sightedness
- ☐ ☐ ☐ Tonsillitis

Gastrointestinal
- ☐ ☐ ☐ Colon trouble
- ☐ ☐ ☐ Constipation
- ☐ ☐ ☐ Diarrhea
- ☐ ☐ ☐ Difficult digestion
- ☐ ☐ ☐ Bloated abdomen
- ☐ ☐ ☐ Excessive hunger
- ☐ ☐ ☐ Liver trouble
- ☐ ☐ ☐ Nausea
- ☐ ☐ ☐ Pain over stomach
- ☐ ☐ ☐ Poor appetite
- ☐ ☐ ☐ Vomiting
- ☐ ☐ ☐ Vomiting of blood

Genitourinary
- ☐ ☐ ☐ Bed-wetting
- ☐ ☐ ☐ Frequent urination
- ☐ ☐ ☐ Kidney infection
- ☐ ☐ ☐ Painful urination
- ☐ ☐ ☐ Prostate trouble

O F C
Skin
- ☐ ☐ ☐ Bruise easily
- ☐ ☐ ☐ Dryness
- ☐ ☐ ☐ Hives or allergy
- ☐ ☐ ☐ Itching
- ☐ ☐ ☐ Skin eruptions (rash)

Respiratory
- ☐ ☐ ☐ Chest pain
- ☐ ☐ ☐ Chronic cough
- ☐ ☐ ☐ Difficult breathing
- ☐ ☐ ☐ Wheezing

Women only
- ☐ ☐ ☐ Hot flashes
- ☐ ☐ ☐ Irregular cycle
- ☐ ☐ ☐ Lumps in breast
- ☐ ☐ ☐ Menopause

Are you pregnant? ☐Yes ☐No
If yes, how many months?____
How many children do you have?____

Check any of the following conditions you currently have or have had:
- ☐ Alcoholism
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Cancer
- ☐ Chicken pox
- ☐ Cholera
- ☐ Cold sores
- ☐ Diabetes
- ☐ Diphtheria
- ☐ Eczema
- ☐ Edema
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fever blisters
- ☐ Goiter
- ☐ Gout
- ☐ Heart disease
- ☐ Herpes
- ☐ Influenza
- ☐ Lumbago
- ☐ Malaria
- ☐ Measles
- ☐ Miscarriage
- ☐ Multiple sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pleurisy
- ☐ Pneumonia
- ☐ Rheumatic fever
- ☐ Scarlet fever
- ☐ Scoliosis
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Typhoid fever
- ☐ Ulcers
- ☐ Venereal disease
- ☐ Whooping cough

Describe problems or other health concerns:_____

Have you seen a chiropractor before? ☐ Yes ☐ No If yes, how long ago? _____
For what reason?

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Are you under the care of a physician? ☐ Yes ☐ No; If yes, for what reason?
Do you smoke or use tobacco products? ☐ Yes ☐ No; If yes, for how long, how frequently, what type of tobacco product?
Do you consume alcoholic beverage? ☐ Yes ☐ No; If yes, how frequently? What Type? (beer, wine, liquor?)

Have you ever:	Yes	No	If yes, briefly explain.
- had a broken bone?	☐	☐	
- been hospitalized?	☐	☐	
- had strains or sprains?	☐	☐	
- had automobile accident	☐	☐	

Do you:		
- have any drug allergy?	☐	☐

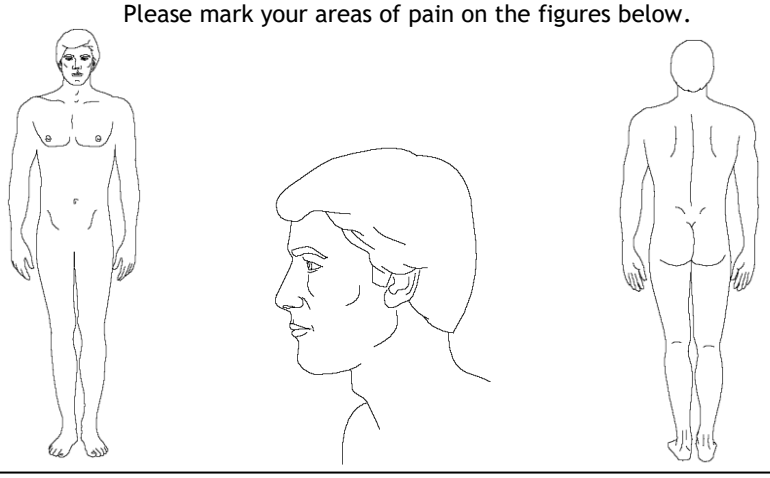
When did you last have:	Never	0-6 mos.	6 -18 mos.	longer
- spinal x-ray?	☐	☐	☐	☐
- spinal examination?	☐	☐	☐	☐
- physical examination?	☐	☐	☐	☐

Please list any other health conditions you have been treated for, or surgery you have had in the last ten years.

FAMILY HEALTH HISTORY: Information about your immediate family members, brothers, sisters, parents, and grandparents will give us a better understanding of your total health picture.

RELATIONSHIP	PRESENT AND PAST HEALTH PROBLEMS

Please mark your areas of pain on the figures below.



Eric D. Dahl, M.S., D.C., CCSP®, Doctor Signature: _____, Date_____