



PATIENT HEALTH HISTORY FORM

Dr. Guy Morrison, R.P.T., D.C.

Name

Date

Referred by

Have you ever been seen by a Chiropractor or Physical Therapist? Yes No Who/When?

What is your major complaint?

Other complaints?

Is this condition getting progressively worse? Yes No Constant Comes & goes

Does this condition interfere with your Work Sleep Daily Routine Other

How long has it been since you felt good?

List other Doctors who have treated this condition

List surgical operations/hospitalizations and years

List all medications/home remedies/supplements

Birth control?

Other medications?

Coffee/Caffeine intake – Cups/day?

Do you smoke? Yes No Do you drink alcohol? Daily On Occasion Rarely Do you Exercise? Daily Weekly Rarely

On a scale, how do you rate your health's importance? (least) 1 2 3 4 5 6 7 8 9 10 (very important)

Other History

Have you been in an auto accident? Past Year Past 5 Years Over 5 Years Describe:

Women: To the best of your knowledge, are you pregnant? Yes No Last Menstrual Period Date?

History:

- | | | |
|---|--|--|
| <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Allergies | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Arm Problems | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Asthma/Emphysema |
| <input type="checkbox"/> Back Disorders | <input type="checkbox"/> Backache | <input type="checkbox"/> Bladder Problems |
| <input type="checkbox"/> Blood in Stool | <input type="checkbox"/> Blood in Urine | <input type="checkbox"/> Bowel Problems |
| <input type="checkbox"/> Breast Pains | <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Circulatory Problem | <input type="checkbox"/> Convulsion |
| <input type="checkbox"/> Persistent Cough | <input type="checkbox"/> Depression | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Eye Problems | <input type="checkbox"/> Fainting Spells |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Gall Bladder | <input type="checkbox"/> Hay Fever |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Hot Flashes | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Kidney Problems |
| <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Lung Problems |
| <input type="checkbox"/> Menstrual Problems | <input type="checkbox"/> Nausea | <input type="checkbox"/> Neck Problems |
| <input type="checkbox"/> Nervous Disorder | <input type="checkbox"/> Paralysis | <input type="checkbox"/> Poor Appetite |
| <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Swollen Joints | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Vaginal Discharge |
| <input type="checkbox"/> Weight Problems | <input type="checkbox"/> Walking Problems | |