Generations Chiropractic
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Onalaska, WI 54650
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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	□	□
Eye problems	□	□	Ear problems	□	□
Asthma	□	□	Sinus problems	□	□
Thyroid problem	□	□	Digestive issues	□	□
Acid reflux	□	□	Gall bladder	□	□
Anxiety	□	□	Depression	□	□
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	□	□	Other_____		
Diabetes	□	□	Do you hear cracking/grinding in your neck? Yes No		

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 □ _____

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)

□ Sitting □ Standing □ Walking □ Bending □ Lifting □Sleeping □ Exercise
□ Coughing □ Twisting □ Looking up/down □ Movement □ Driving □ Household Chores

Do you consume caffeine? If so how much? _____
Do you consume alcohol? If so how much? _____
How much water do you drink? _____