

Health History

Name: _____ Date: _____

What is your occupation? _____ Do you enjoy your job? Yes No

Are you under the care of a physician? Yes No; If yes, for what reason? _____

Indicate the drugs you now take: Pain Killers Muscle relaxants Birth Control Pills

Other drugs? Indicate type and reason: _____

Have you ever taken a medication for an extended period of time? Yes No _____

Do you take any vitamins/minerals? Yes No; If yes please list: _____

Do you smoke? Yes No; Do you have a history of high blood pressure? Yes No

Do you exercise? Yes No; If yes, how much? _____

List any serious accidents, injuries or traumas in your lifetime: _____

List any serious health conditions, hospitalizations or surgeries you have had in your life time:

Check any of the following conditions you have had or currently have:

- | | | |
|--|---|--|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Eczema | <input type="checkbox"/> Loss of Weight, Unexplained |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Edema / Swelling | <input type="checkbox"/> Malaria |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Aneurysm | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Muscle Weakness |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Fainting | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Fatigue / Malaise, Unexplained | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fever (current) | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Bowel Movement Changes/Problems | <input type="checkbox"/> Flu (current) | <input type="checkbox"/> Painful Menstruation |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Gout | <input type="checkbox"/> Rectal Bleeding |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Spinal Canal Stenosis |
| <input type="checkbox"/> Cholera | <input type="checkbox"/> Headaches | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cold Sores | <input type="checkbox"/> Herniated Disc | <input type="checkbox"/> Tingling |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Infection (current) | |
| | <input type="checkbox"/> Joint Pain | |

Family Health History:

Are there any diseases that run in your immediate family (grandparents, parents, brothers, sisters): _____

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