COMMUNITY HEALTH SYSTEMS, INC.

Personal Health History Checklist

Thank you for choosing Community Health Systems, Inc. for you Chiropractic Care! Your Health and Wellbeing is important to us. Please take the time to complete this form so we can better help you. Let us know if you have any questions.

Patient Name: _____ Date of Birth: _____Date: _____

Musculoskeletal:

Chronic pain in:

- ☐ Neck
- ☐ Upper Back
- ☐ Mid Back
- ☐ Low Back
- ☐ Hip (Right/Left)
- ☐ Arm (Right/Left)
- ☐ Leg (Right/Left)
- ☐ Ankle/Foot (Right/Left)
- ☐ Shoulder (Right/Left)
- ☐ Wrist/Hand (Right/Left)

☐ Osteoporosis
☐ Arthritis
☐ Scoliosis
☐ Bursitis of the: _____
☐ Plantar Fasciitis
☐ TMJ pain/dysfunction
☐ Chronic Headaches
☐ Tendonitis of the: _____
☐ Whiplash? When?: _____
☐ Strains/Sprains of the: _____
☐ Dowager (Thoracic) Hump
☐ Poor Posture
☐ On computer more than 2hrs/day. No. of Hrs.: _____

Nervous System:

☐ Dizziness/Vertigo
☐ Migraines
☐ ALS
☐ Multiple Sclerosis
☐ Parkinson's disease
☐ Bell's Palsy
☐ Neuritis
☐ Spinal Cord Injury
☐ Trigeminal Neuralgia
☐ Seizures/Epilepsy
☐ History of Concussion

Respiratory:

☐ Pneumonia
☐ Shortness of Breath
☐ Asthma
☐ Breathing Problems
☐ Sinusitis
☐ COPD
☐ Other: _____

Female Only:

☐ Currently Pregnant: # wks.: _____
☐ Irregular Menstrual Cycle
☐ Menstrual Cramps
☐ Menopause

Digestive

☐ Ulcers
☐ Colitis
☐ Irritable Bowel Syndrome
☐ Crone's Disease
☐ Gluten Intolerance
☐ Constipation
☐ Diarrhea
☐ Gallstones
☐ Gas/Bloating
☐ Chronic Indigestion

Cardiovascular/Circulation:

☐ Heart Problems: _____
☐ Congestive Heart Failure
☐ Stroke
☐ Palpitations
☐ Mitral Valve Prolapse
☐ Anemia
☐ Hemophilia
☐ Hypertension/High Blood Pressure
☐ Low Blood Pressure
☐ Peripheral Artery Disease
☐ Raynaud's Disease
☐ Varicose Veins
☐ Blood Clots/Phlebitis

Skin:

☐ Rash
☐ Fungal Infection
☐ Athlete's Foot
☐ Impetigo
☐ Eczema/Dermatitis
☐ Psoriasis
☐ Easily Irritated Skin
☐ Other: _____

Other:

☐ Diabetes
☐ Pregnancy
☐ Cancer
☐ Kidney Disease
☐ Hepatitis
☐ HIV/AIDS
☐ Lupus
☐ Rheumatoid/Arthritis
☐ Poor Sleep/Insomnia
☐ Allergies_____
☐ Hypothyroidism
☐ Fibromyalgia
☐ Chronic Fatigue
☐ Cysts/Lipomas
☐ Gout in the _____
☐ Orthopedic Pins or Plates
☐ Surgery_____
☐ Auto Accident (when?) _____
☐ Hospitalizations_____
☐ Regular Exercise
☐ No Exercise

Psyche/Mental Wellbeing:

☐ High Stress
☐ Grieving
☐ Worry
☐ Anxiety/Panic Attacks
☐ Bipolar
☐ Syndrome
☐ Drug Addiction
☐ Alcohol Addiction
☐ Gambling Addiction
☐ Little interest or pleasure in doing things
☐ Feeling down, depressed or hopeless
☐ Difficulty coping
☐ I'd like a Behavioral Health referral/consultation

Dental:

☐ Tooth Pain
☐ Jaw Joint Pain/TMJ
☐ Overbite/Underbite
☐ Over 6 months since cleaning
☐ Over 1 year since last dental exam
☐ Other: _____
☐ I'd like a Dental referral/consultation