Lynott
Chiropractic & Acupuncture

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## Patient Health History

Name: ______________ (first) ______________ (middle) ______________ (last) Date: ____/____/____

Date of Birth: ____/____/____ Age: ______ Gender: M/F Marital status: S M D W

Address: ______________________________ City: ______________________

State: ______________ Zip: ______________ Phone: ______________________

*Please complete this questionnaire as thoroughly as possible. Thank you.*

1. Please identify the health concerns that you have in order of importance below:

| Condition | Date of Injury | Past Treatment |
|---|---|---|
| a. | | |
| b. | | |
| c. | | |
| d. | | |

3. If applicable, please list any foods, drugs, or medications you are hypersensitive or allergic to (please include reaction):

______________________________________________

4. Please list any medications (prescribed and over-the-counter), vitamins, and supplements you are currently taking:

______________________________________________

______________________________________________

5. Do you have any reason to believe you may be pregnant? Y N If so, how far along are you?______________

6. Do you have any infectious diseases? Y N If yes, please identify: ______________________

7. **Family History of:** (please circle all those applicable):

Cancer Diabetes Heart Disease High Blood Pressure Stroke
Mental Illness Asthma Hay fever Hives Kidney Disease

10. **Childhood Illness** (please circle any that you have had):

Scarlet Fever Diphtheria Rheumatic Fever Mumps Measles German Measles Chicken Pox

11. **Immunizations** (please circle any that you have had):

Polio Tetanus Rubella/Mumps/Rubella Pertussis Diphtheria Hib Hepatitis B

12. **Hospitalizations and Surgeries:**

| Reason | When | Reason | When |
|---|---|---|---|
| | | | |
| | | | |

Phone: 562-594-6644 Fax: 562-594-6114 Email: Lynottchiro@yahoo.com Website: Lynottchiropractic.com

13. **X-Rays/CAT Scans/MRI's/Special Studies:**

| Reason | When | Reason | When |
|---|---|---|---|
| | | | |
| | | | |

14. **Emotional** (please circle any that you experience):

Mood Swings　Nervousness　Mental Tension

15. **Energy and Immunity** (please circle any that you experience):

Fatigue　Slow Wound Healing　Chronic Infections　Chronic Fatigue Syndrome

16. **Head, Eye, Ear, Nose, and Throat** (please circle any that you experience):

| | | | | |
|---|---|---|---|---|
| Impaired Vision | Eye Pain/Strain | Glaucoma | Glasses/Contacts | Tearing/Dryness |
| Impaired Hearing | Ear Ringing | Earaches | Headaches | Sinus Problems |
| Nose Bleeds | Frequent Sore Throats | Teeth Grinding | TMJ/Jaw Problems | Hay Fever |

17. **Respiratory** (please circle any that you experience):

| | | | |
|---|---|---|---|
| Pneumonia | Frequent Common Colds | Difficulty Breathing | Emphysema |
| Persistent Cough | Pleurisy | Asthma | Tuberculosis |

Shortness of Breath　Other Respiratory Problems: ____________________

18. **Cardiovascular** (please circle any that you experience):

Heart Disease　Chest Pain　Swelling of Ankles　High Blood Pressure

Palpitations/Fluttering　Stroke　Heart Murmurs　Rheumatic Fever　Varicose Veins

19. **Gastrointestinal** (please circle any that you experience):

| | | | | | |
|---|---|---|---|---|---|
| Ulcers | Changes in Appetite | Nausea/Vomiting | Epigastric Pain | Passing Gas | Heartburn |
| Belching | Gall Bladder Disease | Liver Disease | Hepatitis B or C | Hemorrhoids | Abdominal Pain |

20. **Genito-Urinary Tract** (please circle any that you experience):

Kidney Disease　Painful Urination　Frequent UTI　Frequent Urination　Heavy Flow

Kidney Stones　Impaired Urination　Blood in Urine　Frequent Urination at Night

21. **Female Reproductive/Breasts** (please circle any that you experience):

| | | | |
|---|---|---|---|
| Irregular Cycles | Breast Lumps/Tenderness | Nipple Discharge | Heavy Flow |
| Vaginal Discharge | Premenstrual Problems | Clotting | Bleeding Between Cycles |
| Menopausal Symptoms | Difficulty Conceiving | Painful Periods | |

22. **Menstrual/Birthing History:** *(If Applicable)*

1. Age of First Menses: _______
2. # of Days of Menses: _______
3. # of Pregnancies: ________
4. Birth Control Type: ________
5. # of Miscarriages:: ________
6. # of Abortions: ________
7. # of Live Births: ________

23. **Male Reproductive** (please circle any that you experience):

Sexual Difficulties    Prostrate Problems    Testicular Pain/Swelling    Penile Discharge

24. **Musculoskeletal** (please circle any that you experience now):

Neck/Shoulder Pain    Muscle Spasms/Cramps    Arm Pain    Upper Back Pain    Mid Back Pain

Low Back Pain    Leg Pain    Joint Pain (if so, where?): ____________________

25. **Neurologic** (please circle any that you experience):

Vertigo/Dizziness    Paralysis    Numbness/Tingling    Loss of Balance    Seizures/Epilepsy

26. **Endocrine** (please circle any that you experience):

Hypothyroid    Hypoglycemia    Hyperthyroid    Diabetes Mellitus    Night Sweats    Feeling Hot or Cold

27. **Other** (please circle any that you experience):

Anemia    Cancer    Rashes    Eczema/Hives    Cold Hands/Feet

Is there anything else we should know? ____________________

____________________

28. **Lifestyle:**

a. Do you typically eat at least three meals per day?    Y    N    If no, how many? __________
b. Exercise routine: ____________________
c. How many hours per night do you sleep? _______    Do you wake rested?    Y    N
d. Occupation: ______________ Employer: ______________ Hours/Week: _______
e. Nicotine/Alcohol/Caffeine Use: ____________________
f. Have you experienced any major traumas?    Y    N    Explain:

____________________

How did you hear about us? ____________________

Would you like to receive our email newsletter?    Y    N    email address: ____________________