DiSalvatore Chiropractic
1956 West Prospect Road Ashtabula, Ohio 44004
(440) 992-0160 (440) 998-0121(Fax)

CONFIDENTIAL HEALTH HISTORY

Check any of the following diseases that you, your mother, father, sister, brother, son or daughter have had;
Please Specify what type if applicable and who has had the diseases below:

_____ Cancer
_____ Lung Disease
_____ Diabetes
_____ Septicemia
_____ Kidney Disease
_____ Heart Disease
_____ Hypertension
_____ Stroke/Brain Attack
_____ Clotting Disorder
_____ Osteoporosis
_____ Psychological Disorder
_____Gastrointestinal Disorder

Please specify if any of these diseases apply to just yourself:
____ Measles ____ Polio ____ Tuberculosis ____ Epilepsy ____ Anemia ____ Mumps ____ Small Pox ____Eczema
____ Chicken Pox ____ Arthritis ____ Whooping Cough____ Rheumatic Fever ____ Thyroid ____ HIV Positive

Exercise
_____ None
_____ Moderate
_____ Daily
_____ Heavy

Work Activity
_____ Sitting
_____ Standing
_____ Light Labor
_____ Heavy Labor

Habits
_____ Smoking
_____ Alcohol
_____ Coffee/Caffeine
_____ High Stress Level

Packs/Day _____
Drinks/Week _____
Cups/Day _____
Reason _____

CHECK ANY OF THE FOLLOWING YOU HAVE HAD IN THE PAST SIX MONTHS:

Musculoskeletal
_____ Low Back Pain
_____ Pain Between Shoulders
_____ Neck pain
_____ Arm pain
_____ Joint Pain/Stiffness
_____ Walking Problems
_____ Difficulty Chewing/Clicking Jaw
_____ General Stiffness

Nervous System
_____ Nervous
_____ Numbness
_____ Paralysis
_____ Dizziness
_____ Forgetfulness
_____ Confusion/Depression
_____ Fainting
_____ Convulsions
_____ Cold/Tingling Extremities
_____ Stress

General
_____ Fatigue
_____ Allergies
_____ Loss of Sleep
_____ Fever
_____ Headaches

Gastro-intestinal
_____ Poor/Excessive Appetite
_____ Excessive Thirst
_____ Frequent Nausea
_____ Vomiting
_____ Diarrhea
_____ Constipation
_____ Hemorrhoids
_____ Liver Problems
_____ Gall Bladder Problems
_____ Weight Trouble
_____ Abdominal Cramps
_____ Gas/Bloating after meals
_____ Heartburn
_____ Black/ Bloody Stool
_____ Colitis

Genito-Urinary
_____ Bladder Trouble
_____ Painful/Excessive Urination
_____ Discolored Urine

CVR
_____ Chest Pain
_____ Short Breath
_____ Blood pressure problems
_____ Irregular heartbeat

CVR Cont'd
_____ Heart Problems
_____ Lung Problems/Congestion
_____ Varicose Veins
_____ Ankle Swelling

EENT
_____ Vision Problems
_____ Dental Problems
_____ Sore Throat
_____ Ear Aches
_____ Hearing difficulty
_____ Stuffed Nose

Male/Female
_____ Menstrual Irregularity
_____ Menstrual Cramps
_____ Vaginal Pain/Infection
_____ Breast Pain/ Lumps
_____ Prostate

Females Only

When was your last period? _____
Are you pregnant? _____ Yes _____ No

Do you have a pacemaker? Y / N **Have you ever had a hip or knee replacement? Y / N**

What medications or drugs are you taking? (check those that apply): Pain Killers ____ Insulin _____
Cholesterol Meds ___ Blood Pressure Meds ___ Muscle Relaxers ___ Birth Control ___
Other:_____
_____

See medication list provided: (check here) _____

Nutritional Supplements: _____
Allergies: _____
Hospitalizations/Operations: _____
Severe Trauma/Accidents/Falls_____

Signature: _____ **Date**: _____