

DiSalvatore Chiropractic

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CONFIDENTIAL HEALTH HISTORY

Below is a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of care.

Check any of the following diseases you have had:

- | | | | |
|---|--|------------------------------------|---|
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Mumps | <input type="checkbox"/> Influenza | <input type="checkbox"/> Mental Disorders |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Small Pox | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Measles |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Cancer | <input type="checkbox"/> Lumbago | <input type="checkbox"/> HIV Positive |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Eczema | |

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 _____

Allergies: _____

Current Medications: _____

Supplements/Nutrition: _____

Hospitalizations/Operations: _____

Fractures/Dislocations/Sprains: _____

Severe Trauma/Accident/Falls (ex. car accident, etc.) _____

FAMILY HISTORY

Include Information on brothers, sisters, parents and grandparents. **DO NOT INCLUDE YOURSELF.**

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Thyroid Disease/Goiter | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Muscle, Bone or Nerve Disease |

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

Musculo-Skeletal

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

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

CVR Cont'd

- Heart Problems
 Lung Problems/Congestion
 Varicose Veins
 Ankle Swelling
 Stroke

Nervous System

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

Genito-Urinary

- Bladder Trouble
 Painful/Excessive Urination
 Discolored Urine

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/Sexual Dysfunction
 Other Problems

General

- Fatigue
 Allergies
 Loss of Sleep
 Fever
 Headaches

CVR

- Chest Pain
 Short Breath
 Blood pressure problems
 Irregular heartbeat

Females Only

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

Signature: _____

Date: _____