# Personal History Survey

Date: _____

*(please print)*

Name:_____ Age:_____ ❑ Male ❑ Female Email:_____

(Email is used for office communications with patient)

Source of Referral:_____ Occupation:_____

Please check ✓ the following conditions which you have or have had in the past:

❑ Tonsillitis ❑ Meningitis ❑ Heart Trouble ❑ Diabetes
❑ Pneumonia ❑ Thyroid Trouble ❑ High Blood Pressure ❑ Epilepsy
❑ Asthma ❑ Gall Bladder Trouble ❑ Stroke ❑ Allergies
❑ Hepatitis / Jaundice ❑ Mental Illness ❑ Headaches ❑ Fracture *(where?)*_____

❑ Surgery?_____

❑ Accidents?_____

Please check ✓ the following symptoms which presently apply:

**Eyes**
❑ Blurry Vision
❑ Tearing
❑ Sensitive to light

**Ears**
❑ Ringing
❑ Earaches
❑ Infection
❑ Deafness

**Nose**
❑ Nasal Stuffiness
❑ Bleeding
❑ Sinus Trouble
❑ Frequent Colds

**Throat**
❑ Frequent Soreness
❑ Difficulty Swallowing

**Sleep**
❑ Stomach
❑ Right Side
❑ Left Side
❑ Back

**Nervous System**
❑ Tension
❑ Depression
❑ Fatigue
❑ Blackouts

**Chest**
❑ Wheezing
❑ Tightness
❑ Difficult Breathing

**Head**
❑ Dizziness / Vertigo
❑ Fainting
❑ Head Injury

**Skin**
❑ Easy Bruising
❑ Lumps
❑ Rashes / Eruptions
❑ Changes in Hair

**Limbs**
❑ Varicose Veins
❑ Swelling of Hands / Feet

**Weight**
❑ Gain
❑ Loss

**Urination**
❑ Urinary Infections
❑ Burning / Painful
❑ Discoloured Urine
❑ Excessive Urination

**Stomach / Intestines**
❑ Nausea
❑ Vomiting
❑ Belching
❑ Passing Gas
❑ Diarrhea
❑ Constipation
❑ Hemorrhoids
❑ Black Tarry Stool

**Musculoskeletal**
❑ Joint Pains
❑ Stiffness
❑ Muscle Pain
❑ Pins & Needles
❑ Muscle Cramps
❑ Weakness in Muscles
❑ Numbess

**Female** *(only)*
❑ Lumps in Breasts
❑ Painful Breasts
❑ Irregular Menstrual Periods
❑ Painful Mestrual Periods

**Male** *(only)*
❑ Testicular Pain

Please check ✓ any habits which apply and indicate quantities/frequencies:

❑ Coffee _____ ❑ Alcohol _____ ❑ Smoke _____ ❑ Soft Drinks _____ ❑ Energy Drinks _____

Please check ✓ a description of your pillow:

❑ Contoured for Neck
❑ 10" thick* ❑ 5" thick* ❑ 2" thick*

**Before being pushed down*

***Please turn page over →***

List all medications you are taking:_____

List all supplements you are taking:_____

Have you been X-rayed before?_____When?_____What for?_____

Please describe the principal health concerns for which you came to this office:_____

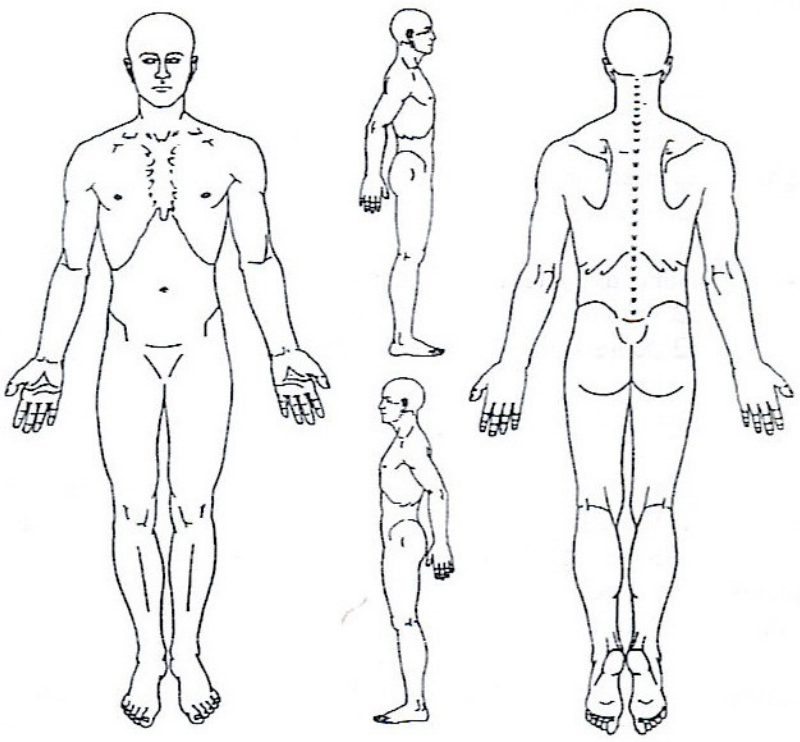
_____

List any doctors you have seen for these concerns:_____

Have you lost any days of work because of this? ❑ Yes ❑ No Dates:_____

Use the letters below to indicate the type and location of your sensations right now.

**A** = Ache **B** = Burning **N** = Numbness F = Stiffness
**P** = Pins & Needles **S** = Stabbing O = Other



List the concerns that you are most interested in changing. List in order of importance.

1. _____
2. _____
3. _____
4. _____

What activities/movements produce discomfort? List in order of severity. (eg. Sitting, walking, bending, lying).

1. _____
2. _____
3. _____
4. _____