

# GENERAL HEALTH HISTORY **Kuns Chiropractic – 405 NE Division Gresham OR 97030**

Patient Name \_\_\_\_\_ *Mark the conditions that apply to you.*

- | Past                     | Present                  |                         | Past                     | Present                  |                                  |
|--------------------------|--------------------------|-------------------------|--------------------------|--------------------------|----------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Headaches               | <input type="checkbox"/> | <input type="checkbox"/> | Urinary Problems                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Migraines               | <input type="checkbox"/> | <input type="checkbox"/> | Easy Bruising                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Shortness of Breath     | <input type="checkbox"/> | <input type="checkbox"/> | Tobacco Use                      |
| <input type="checkbox"/> | <input type="checkbox"/> | Allergies / Asthma      | <input type="checkbox"/> | <input type="checkbox"/> | Dental Problems                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Medication Side Effects | <input type="checkbox"/> | <input type="checkbox"/> | Fibromyalgia                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes                | <input type="checkbox"/> | <input type="checkbox"/> | Blood Thinner use                |
| <input type="checkbox"/> | <input type="checkbox"/> | Hands or Feet cold      | <input type="checkbox"/> | <input type="checkbox"/> | HIV Positive                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Muscle aches            | <input type="checkbox"/> | <input type="checkbox"/> | Cancer                           |
| <input type="checkbox"/> | <input type="checkbox"/> | Trouble Walking         | <input type="checkbox"/> | <input type="checkbox"/> | Depression                       |
| <input type="checkbox"/> | <input type="checkbox"/> | Leg / Foot Numbness     | <input type="checkbox"/> | <input type="checkbox"/> | Alcohol Use                      |
| <input type="checkbox"/> | <input type="checkbox"/> | Fainting                | <input type="checkbox"/> | <input type="checkbox"/> | ___High or ___Low Blood Pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | Gall Bladder Trouble    | <input type="checkbox"/> | <input type="checkbox"/> | Stroke History                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Ringing in Ears         | <input type="checkbox"/> | <input type="checkbox"/> | High Cholesterol                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Ear Problems            | <input type="checkbox"/> | <input type="checkbox"/> | TMJ                              |
| <input type="checkbox"/> | <input type="checkbox"/> | Sleeping Problems       | <input type="checkbox"/> | <input type="checkbox"/> | Digestive Problems               |
| <input type="checkbox"/> | <input type="checkbox"/> | Vision Problems         | <input type="checkbox"/> | <input type="checkbox"/> | Pain all Over                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Thyroid Problems        | <input type="checkbox"/> | <input type="checkbox"/> | Tension / Irritability           |
| <input type="checkbox"/> | <input type="checkbox"/> | Liver Disease           | <input type="checkbox"/> | <input type="checkbox"/> | Chest Pains                      |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney Problems         | <input type="checkbox"/> | <input type="checkbox"/> | Heart Pacemaker                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Light Bothers Eyes      | <input type="checkbox"/> | <input type="checkbox"/> | Heart Problems                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Other _____             |                          |                          |                                  |

- List any medications you are taking: \_\_\_\_\_  
\_\_\_\_\_
- Please list all doctors you are currently seeing: \_\_\_\_\_  
\_\_\_\_\_
- Has any Doctor or other professional advised you to "Go to a Chiropractor ":  No  Yes, Name \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## PAST HISTORY

- List any past auto collisions: \_\_\_\_\_ Was any care received? \_\_\_\_\_
- List any past work injuries: \_\_\_\_\_ Was any care received? \_\_\_\_\_
- List any past sport, recreational, or home injuries \_\_\_\_\_
- Please describe any past conditions and treatment received: \_\_\_\_\_  
\_\_\_\_\_
- Please list any past hospitalizations and surgeries: \_\_\_\_\_  
\_\_\_\_\_

## FAMILY HISTORY

- Father's side:  Heart Disease  Cancer  Diabetes  Heavy Medication use  Arthritis  Other \_\_\_\_\_
- Mother's side:  Heart Disease  Cancer  Diabetes  Heavy Medication use  Arthritis  Other \_\_\_\_\_
- Is there any other family history you want us to know? \_\_\_\_\_