Journey Through Healing Chiropractic Center, LLC

830 Saginaw Street South
Salem, OR 97302

Tel 503-480-0200 Fax 503-480-0203
journeythroughhealingchiropractic.com

Health History

Patient Name: ____ Date: ______________________

Have you seen a Chiropractor before? Yes_____ No_____

If Yes, when and for what reason(s)? ____

Is your condition related to: ◯ Auto Accident ◯ Illness ◯ Work Related ◯ Other

Date of onset for your condition: ____________________

Do you Smoke? Y___ N___ If yes, how much? _________ per day. What age did you start smoking? _____

Please Mark all symptoms/conditions that you *previously (P)* or are *currently (C)* experiencing.

Head:	***(P)***	***(C)***
Headaches	◯	◯
Head feels heavy	◯	◯
Loss of Memory	◯	◯
Light Headed	◯	◯
Fainting (syncope)	◯	◯
Light sensitive	◯	◯
Loss of smell	◯	◯
Loss of Taste	◯	◯
Loss of Balance	◯	◯
Dizziness	◯	◯
Loss of Hearing	◯	◯
Pain in ears	◯	◯
Ringing in ears	◯	◯
Buzzing in ears	◯	◯

Neck:	***(P)***	***(C)***
General Pain	◯	◯
Pain w/ motion	◯	◯
Pain radiating:		
into arms or fingers	◯	◯
Neck feels out of place	◯	◯
Pinched Nerve	◯	◯
Muscle spasms	◯	◯
Popping Sounds	◯	◯
Grinding sensation	◯	◯
Neck Arthritis	◯	◯

Shoulders:	***(P)***	***(C)***
General pain	◯	◯
Pain across shoulders	◯	◯
Bursitis	◯	◯
Arthritis	◯	◯
Shoulder tension	◯	◯
Muscle spasms	◯	◯
Unable to raise arm(s):		
To shoulder level	◯	◯
Over head	◯	◯

Mid Back:	***(P)***	***(C)***
General Pain	◯	◯
Pain between Scapula	◯	◯
Sharp stabbing pain	◯	◯
Pain in the rib area	◯	◯
Muscle spasms	◯	◯

Low Back:	***(P)***	***(C)***
General Pain	◯	◯
Pain INCREASED with:		
Coughing/Sneezing	◯	◯
Lifting	◯	◯
Stooping	◯	◯
Standing	◯	◯
Bending	◯	◯
Squatting	◯	◯
Sitting	◯	◯

Low back:	***(P)***	***(C)***
Burning	◯	◯
Pinching	◯	◯
Herniated Disc	◯	◯
Bulging Disc	◯	◯
Muscle Spasm	◯	◯
Arthritis	◯	◯

Arms and Hands:	***(P)***	***(C)***
Pain in upper arm	◯	◯
Pain in forearm	◯	◯
Pain in hand(s)	◯	◯
Pain in fingers	◯	◯
Nerve pain in arm	◯	◯
Nerve pain in forearm	◯	◯
Nerve pain in wrist	◯	◯
Nerve pain in fingers	◯	◯
Pins / needles in:		
arm(s)	◯	◯
forearm	◯	◯
hands /fingers	◯	◯
Cold hands	◯	◯
Numb hands	◯	◯
Fingers turn blue	◯	◯
Fingers going numb	◯	◯
Loss of grip strength	◯	◯
Swollen wrist/hand	◯	◯
Swollen fingers	◯	◯

Continue on Back side ---->

Journey Through Healing Chiropractic Center, LLC

830 Saginaw Street South
Salem, OR 97302
Tel 503-480-0200 Fax 503-480-0203
journeythroughhealingchiropractic.com

Please Mark all symptoms/conditions that you previously (P) or are currently (C) experiencing.

Arms and Hands:	***(P)***	***(C)***
Arthritis in wrist	◯	◯
Arthritis in fingers	◯	◯
Carpal Tunnel	◯	◯

Hips, Legs, and Feet	***(P)***	***(C)***
Pain in buttocks	◯	◯
Pain in hip joint	◯	◯
Pain in Knees	◯	◯
Pain down leg	◯	◯
Leg cramps	◯	◯
Pins and needles	◯	◯
Leg Numbness	◯	◯
Numbness in feet	◯	◯
Cramps in feet	◯	◯
Feet feel cold	◯	◯
Numb feet	◯	◯
Toes turn blue	◯	◯
Toes are numb	◯	◯
Swollen ankles	◯	◯

Hips, Legs, and Feet	***(P)***	***(C)***
Swollen feet	◯	◯
Swollen toes	◯	◯
Joint pain in feet	◯	◯
Toes go to sleep	◯	◯
Arthritis in hip	◯	◯
Arthritis in knee	◯	◯
Arthritis in feet/toes	◯	◯

Have you had or are you currently having:	***(YES)***	***(NO)***
Allergies	◯	◯
Alcoholism	◯	◯
Anemia	◯	◯
Asthma	◯	◯
Bruise Easily	◯	◯
Cancer	◯	◯
Constipation	◯	◯
Depression	◯	◯
Diabetes	◯	◯

Have you had or are you currently having:	***(YES)***	***(NO)***
Digestive problems	◯	◯
Fatigue	◯	◯
Frequent Urination	◯	◯
High Blood Pressure	◯	◯
Irregular Heart Rate	◯	◯
Kidney Stones	◯	◯
Nose Bleeds	◯	◯
Pacemaker	◯	◯
Prostate Trouble	◯	◯
Sinus Infections	◯	◯
Sleep Problems	◯	◯
Stroke	◯	◯
Swelling Ankles	◯	◯
Swollen Joints	◯	◯
Thyroid Conditions	◯	◯
Tuberculosis	◯	◯
Ulcers	◯	◯
Varicose Veins	◯	◯

Please list ANY family related illnesses or issues and your relationship.

____

____

Have you had X-Rays taken of your spine: Yes___ NO___ When? ______________________________

Other X-Rays (list body part and when):____

Have you had an **MRI**? Yes___ No___ When?_________ **CT SCAN**? Yes___ No___ When?_______________

Female only: Date of last Period__________ Are you Pregnant? Yes___ No___ How long? ______________

Do you suffer from PMS? Yes___ No___

Which of these do you experience if any? ◯ Menstrual pain ◯ Irregularity

◯ Cramping ◯ Water Retention ◯ Abnormal PAP Smear ◯ Hot Flashes

Have you had a Hysterectomy? Yes___ No___ If yes, was it: Partial? __________ or a Complete ?__________

Are you in Menopause? Yes___ No___ If yes, when did it start? ______________________________

Patient Signature: ______________________________ **Date:**________________