Active Health Chiropractic & Therapy
4100 Duval Rd Bldg 4, Suite 203
Austin, Texas 78759
(512) 833-7700

CONFIDENTIAL PATIENT HISTORY

Name:_____________________________________ Date of Birth:_______________________

1. Please circle the conditions you currently have and underline the conditions you have had in the past.

General	Gastro-intestinal	Eye/Ear/Nose/Throat	Respiratory
Headache	Poor appetite	Poor vision	Chronic cough
Fever	Poor digestion	Crossed eyes	Spitting blood
Chills	Excessive hunger	Pain in eyes	Spitting phlegm
Night sweats	Belching or gas	Deafness	Chest pain
Fainting	Nausea/vomiting	Earaches	Trouble breathing
Dizziness	Pain over stomach	Ear noises	Pneumonia
Convulsions	Constipation	Ear discharge	Wheezing
Loss of sleep	Diarrhea	Nasal obstruction	Tuberculosis
Fatigue	Colon trouble	Nose bleeds	Asthma
Nervousness	Hemorrhoids	Sore throat	
Loss of weight	Liver trouble	Hoarseness	Genito-Urinary
Numbness or pain in arms/legs/hands	Jaundice	Hay fever	Frequent urination
Mental/Emotional disorders	Gallbladder trouble	Astigmatism	Painful urination
Alcoholism	Hepatitis	Frequent colds	Blood in urine
Cancer	Ulcers	Enlarged thyroid	Kidney infection
Polio	Appendicitis	Tonsillitis	Bed wetting
Mumps		Sinus trouble	Inability to control urine
Gout	**Cardiovascular**	Goiter	Prostate trouble
Diabetes	Rapid heartbeat		Venereal disease
HIV/AIDS	Slow heartbeat	**Muscles & Joints**	
	High blood pressure	Weakness	**Skin or allergies**
For women only	Low blood pressure	Twitching	Skin eruptions
Painful periods	Pain over heart	Stiff neck	Itching
Excessive flow	Previous heart trouble	Back aches	Bruise easily
Irregular cycle	Swelling of ankles	Swollen joints	Dryness
Cramps or backaches	Poor circulation	Tremors	Sensitive skin
Miscarriage	Varicose veins	Foot trouble	Hives
Vaginal Discharge	Stroke	Painful tailbone	Allergies
Are you pregnant? Yes/No	Arteriosclerosis	Pain between shoulders	Eczema
If yes, what trimester ____	Heart Disease	Hernia	Measles
	Anemia	Spinal curvature	Chicken pox
		Arthritis	Small pox
		"Whip lash" injury	

2. Give EXACT DATES and results if possible. When was your last:

Physical examination_________________________ Blood test_________________ Urine test___________________

Chest x-ray__________________________________ Spinal x-ray________________ Dental x-ray_________________

Prostate exam______________ FEMALES ONLY: Menstrual cycle_______________ Pap smear__________________

3. What are your life cycle habits? Tobacco (packs/day)_______Alcohol (drinks/day)______

Sleep (hours/day)______ Waking up (# of times/night)_______

Exercise/Hobbies____

Do you "pop" or "crack" your own spine? Yes/No How often?___________________________

Name:______________________________________ Date of Birth:____________________

4. Have you had any previous surgeries or hospitalizations?

Date	Reason for surgery/ hospitalization	Procedure performed	Name/Type of Dr.

5. Previous accidents or injuries (Sports, work, auto accident, concussions)?

Date	Accident or Injury

6. What medications are you currently taking (Including prescription and over the counter)?

Name of Drug	Dosage	Condition Used For	Date Started

7. List all allergies? ____

8. Family History: Has your mother and/or father ever had any of the following:
(Please mark **M** for mother, **F** for father or **B** for both)

☐ High Blood Pressure	☐ Asthma	☐ Arthritis-Rheumatism
☐ Heart Attack	☐ Diabetes	☐ Mental Illness
☐ Emphysema	☐ Kidney Disease	☐ Thyroid Disease
☐ Seizure-Convulsions	☐ Ulcer or Stomach Problems	☐ Circulation
☐ HIV Positive	☐ Stroke	☐ Cancer

I have read the above information and certify it to be true and correct to the best of my knowledge, and here by authorize this office to provide me with chiropractic care in accordance with this state's statutes.

Signature (Guardian if under 18): ____ Date: ________________