

DYNAMIC HEALTH INSTITUTE

CURRENT HEALTH HISTORY

Name _____ Today's Date ___ / ___ / ___ Age _____

Type of Injury / Condition: What is the **main** problem for which you are seeking treatment? _____

When did this **main** problem begin? _____ Is this problem a result of (circle one): Auto Sports Work Other

Please give details of how your pain/injury or condition occurred: _____

What types of treatment have you tried for this main problem?

Dates	Please Describe
Surgery	
Chiropractic	
Physical Therapy	
Medication(s)	
Other	

What diagnostic studies have been done for this main problem?

	Dates	Results		Dates	Results
X-rays			MRI		
CT Scan			Bone Scan		
Other					

Have you had the same or similar injuries/problems in the past? Yes / No (circle one) if yes, please describe:

Are there any other problems or conditions for which you seeking treatment or attention from this office? Describe here:

When did this second problem begin? _____ Please give details of how this problem/condition occurred:

What types of treatment have you tried for this second problem?

Dates	Please Describe
Surgery	
Chiropractic	
Physical Therapy	
Medication(s)	
Other	

What diagnostic studies have been done for this second problem?

	Dates	Results		Dates	Results
X-rays			MRI		
CT Scan			Bone Scan		
Other					

Are there any other problems or conditions for which you seeking treatment or attention from this office? Describe here:

CURRENT MEDICATIONS (INCLUDING VITAMINS AND SUPPLEMENTS)

Medication or Supplement	Frequency of Use	Medication or Supplement	Frequency of Use

ALLERGIES

Medication or Substance	Reaction	Medication or Substance	Reaction

LIFESTYLE - ATHLETIC / SPORTING ACTIVITIES

Smoke	Packs/day for _____ years
Drink caffeine	Cups or Cans /day
Drink alcohol	Type _____ Amount per week
Use recreational drugs	Type _____ Amount per week

	Amounts/Times per week	Previous Injuries
Sport 1:		
Sport 2:		
Sport 3:		

MEDICAL HISTORY (please ✓ all PRESENT conditions – and X all PAST conditions)

HEENT		RESPIRATORY		MUSCULOSKELETAL	
Headaches		Asthma		Herniated Disc Location:	
Migraines		Bronchitis/Pneumonia		Broken Bones Specify:	
Concussion		COPD		Chronic back pain	
Head injury		Shortness of breath w/exercise		Chronic neck pain	
Eye problems		Coughing during / after exercise		Joint pain Specify:	
Wear glasses/contacts		Use an inhaler		Whiplash Injury	
				Shoulder injury R or L	
		GASTRO-INTESTINAL			
Sinus problems		Heartburn/indigestion		Knee injury R or L	
Frequent colds		Ulcers		Ankle injury R or L	
		Diarrhea		Wear orthotics in shoes	
CARDIOVASCULAR					
High blood pressure		Constipation		Scoliosis	
Angina or Chest pain with exertion		Gall bladder problems		Tendonitis Location:	
Palpitations		Hemorrhoids		Bursitis	
Irregular heart beat		Irritable Bowel		Rheumatoid arthritis	
Heart failure		Colitis / Crohn's disease		Degenerative arthritis	
Get lightheaded/faint with exercise		Blood in stool/black tarry stools		Short leg	
High cholesterol		Diverticulosis/Diverticulitis		Osteoporosis	
Stroke				Carpal tunnel syndrome/repetitive stress syndrome	
		GENITOURINARY		Other:	
Aneurysm		Frequent urinary tract infections			
Heart attack		Kidney stones			
				ENDOCRINE	
Phlebitis/ blood clots in legs		Prostate trouble		Diabetes – insulin dependent	
Varicose veins		Kidney failure		Diabetes – non-insulin dependent	
				Hypothyroid (underactive)	
NEUROLOGICAL/PSYCHOLOGICAL		FEMALE ONLY			
Nerve injury Specify:		Identify problem:		Hyperthyroid (overactive)	
Stress which effects daily life or sleep				Gout	
Anxiety				Easily fatigues	
Depression					
				OTHER	
Panic attacks				Cancer Type:	
Dizziness				Anemia	
Convulsions / seizures				Other:	
MS					
Other:		Other:		Other:	

PAIN ASSESSMENT

Rate your pain (1 = minimal 10 = severe)

How would you rate your pain now? (Circle one) 1 2 3 4 5 6 7 8 9 10

At it's worst: 1 2 3 4 5 6 7 8 9 10 At its best: 1 2 3 4 5 6 7 8 9 10

Is your pain (circle one): Getting Better Getting Worse Staying the Same

What makes your pain worse? _____

What makes your pain better? _____

How would you describe the nature or character of your pain? _____

Where is the majority of your pain located? _____

Does your pain or symptoms travel or radiate to other areas? Yes / No (circle one). If yes, please describe:

Please mark the area and type of pain on the illustration using the code list below:

MS = muscle spasm P = Pain T = Tingling N = Numbness

B = burning ST = stabbing SH = sharp D = dull C = constant A = ache SF = stiffness
 SO = soreness CG = comes and goes

