Dr. Richard E. Picard
Chiropractic Physician

Name: _____ Date: _____ File # _____

Confidential Health History

The items below may relate to your current condition. Mark (Y) if any of the following items pertain to you or leave it blank if none of these items are associated with your current level of health.

General Health Status
_____ Loss of sleep
_____ Fatigue
_____ Weight gain or loss
_____ Fever
_____ Chills
_____ Nervousness
_____ Night Sweats
_____ Allergies
_____ Anemia
_____ Diabetes
_____ Cancer
_____ Thyroid Disease
_____ Heart Disease
_____ HIV (AIDS)
_____ Hepatitis A, B or C
_____ Epstein Barr Virus (Mono)
_____ Lyme Disease (tick-bite)

_____

ENT
_____ Poor Vision
_____ Eye Disease
_____ Hearing Problems
_____ Ear Infections
_____ Sinus Problems / Infections
_____ Dental Problems
_____ Hoarseness
_____ Sore Throat
_____ Tonsillectomy

_____

Gastrointestinal
_____ Poor digestion or appetite
_____ Difficulty swallowing
_____ Current Nausea
_____ Stomach or abdominal pain
_____ Ulcer or GERD
_____ Liver Disease
_____ Gall bladder removed / stone
_____ Diarrhea or Constipation
_____ Celiac Disease (gluten)
_____ IBS, Diverticulitis, Chron's
_____ Jaundice
_____ Hernia
_____ Hemorrhoids
_____ Appendicitis (past)

Respiratory
_____ Difficulty breathing
_____ Chronic cough
_____ Asthma
_____ Bronchitis
_____ Pneumonia
_____ Tuberculosis
_____ Excessive phlegm
_____ Emphysema
_____ Spitting up blood

_____

Cardiovascular
_____ Irregular heart beat
_____ High blood pressure
_____ Stroke
_____ Previous heart trouble
_____ Ankle swelling
_____ Artery disease
_____ Rheumatic fever
_____ Pacemaker

_____

Skin
_____ Acne
_____ Bruising easily
_____ Itching
_____ Psoriasis / Eczema
_____ Hives / Rashes
_____ Melanoma or new growth

_____

Men Only
_____ Prostate problems
_____ Low Testosterone
_____ Testicular problems
_____ Urinary problems

_____

Women Only
_____ Painful periods
_____ Irregular cycles
_____ PMS
_____ Menopause / Hot flashes
_____ Birth control pill
_____ Urinary / Yeast Infections
_____ Hormone Therapy
_____ Hysterectomy
_____ Breast augmentation

Neurologic
_____ Headache
_____ Dizziness
_____ Fainting
_____ Weakness
_____ Numbness or tingling
_____ Burning sensation
_____ Arm or Leg pain
_____ Psychological disorder
_____ Neurological disease
_____ Epilepsy / Seizures

_____

Musculoskeletal
_____ Neck pain or stiffness
_____ Back pain or stiffness
_____ Joint pain or stiffness
_____ Swollen Joints
_____ Muscular pain or stiffness
_____ Arthritis
_____ Scoliosis / spinal curvature

_____

Exercise
_____ None
_____ Less than 3X per week
_____ More than 3X per week

_____

Habits
_____ Smoking
_____ Drinking (socially / binge)
_____ Recreational drug use

_____

Family History
_____ Heart Disease
_____ High Blood Pressure
_____ Cancer
_____ Diabetes
_____ Thyroid Disease

_____

List All Medications Here
_____
_____
_____
_____
_____
_____