Serenity Family Chiropractic, P.C.

10739 Highland Rd; White Lake, MI 48386

Health History

Patient Name _____ Date: _____ PM # _____

Please circle any other complaints you have experienced in your past:

MUSCULOSKELETAL			
Sciatica	Spinal curvature	Hip pain	Carpal Tunnel
Muscles spasms in neck	Tightness of shoulders/ arms	TMJ pain	Syndrome
Hernia	Neck pain	Pain in shoulder/arm/hand	Painful joints
Sacroiliac backache	Mid back pain	Numbness in arms/hands	Swollen Joints
Numbness in legs or feet	Low back pain		
CARDIOVASCULAR			
Chest pain	High blood pressure	Poor circulation	Aortic aneurysm
Heart attack	Low blood pressure	Heart disease	Deep vein thrombosis
Congestive Heart Failure	Arteriosclerosis	Excessive bruising	Heart valve disease
	Stroke/TIA	High cholesterol	Varicose veins
CONSTITUTIONAL			
Fatigue	Sleeping problems	Sudden weight changes	Low energy
Anemia	Anxiety	Stress	Excessive hunger
Soreness upon waking	Poor appetite	Afternoon yawning	Excessive thirst
Irritability	Fever	Night sweats	
NEUROLOGICAL			
Shooting pain in neck/shoulder	Migraine headaches	Loss of memory	Dizziness
	Headache	Depression	Fainting
Shooting head pains	Tension headaches	Epilepsy	
RESPIRATORY			
Sinus problems	Hay fever	Shortness of breath	Emphysema
Allergies	Asthma	Apnea	Pneumonia
Persistent cough	COVID-19		
SENSORY			
Loss of taste	Lights bother eyes	Hearing loss	Double vision
Loss of balance	Abnormality of gait	Loss of smell	Vision flashes/floaters
Blurred vision	Chronic ear infections	Ear pain	
DIGESTIVE			
Tonsillitis	Anorexia/bulimia	Heartburn/reflux	Bloating/gas
Stomach pain	Ulcers	Difficulty swallowing	Poor appetite
Gallbladder	Food sensitivities	Alternating constipation/diarrhea	Nausea

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ENDOCRINE			
Thyroid	Cold hands/fingers	Immune disorders	Frequent infections
Cold feet/toes	Diabetes	Hypoglycemia	Swollen glands
GENITOURINARY			
Bed wetting	Kidney stones	Menstrual irregularity	Abnormal pap smear
Pre-menstrual Headache	Hemorrhoids	Lack of bladder control	Bleeding between periods
Blood in urine	Erectile dysfunction	Infertility	Hot flashes
Prostate troubles	Menstrual cramps/pain	Breast lump	
ILLNESSES			
AIDS	Gout	Pneumonia	Tuberculosis
Alcoholism	Hepatitis	Polio	Multiple sclerosis
Arthritis	Measles	Scarlet fever	Rheumatic fever
Chicken pox	Mumps	STD	Cancer
SURGERIES			
Appendix removed	Cosmetic surgery	Pacemaker	_____
Heart bypass	Elective Eye surgery	Tonsillectomy	_____
Cancer	Hysterectomy	Vasectomy	_____

INJURIES

Car accident(s) _____

Work accident(s) _____

Broken bone(s) _____

Hospitalization(s) _____

Medication(s) _____

_____

Drug Allergies: _____ NKDA

RELATIVES	**ILLNESSES**	**Age at time of death**	**Cause of death**
Mother	_____	_____	_____
Fathe	_____	_____	_____
Sibling	_____	_____	_____
Sibling	_____	_____	_____
Sibling	_____	_____	_____

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SOCIAL

Exercising: Daily Weekly How much? _____ Soft drinks: Daily Weekly How much? _____

Pain relievers: Daily Weekly How much? _____ Fast food: Daily Weekly How much? _____

Water intake: Daily Weekly How much? _____

LIFESTYLE

How much sleep do you average per night? _____ Hours Do you wake feeling rested? Yes No Sometimes

What is your preferred sleeping position? Side Back Stomach Other _____

Eating habits: Skip breakfast Two meals per day Three meals per day Snacking between meals

What are the major stressor(s) in your life?

_____

Please read carefully:

I understand that the chiropractic is a separate and distinct healing art form from medicine and *does not proclaim to cure any named disease or entity.* **Initials** _____

I realize that an x-ray examination may be hazardous to an unborn child and I certify that the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY): _____ **Initials** _____

To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

Patient Signature: _____ **Date:** _____