HEALTH HISTORY

Patient Name:____ **Date:**_____________________

What treatment(s) have you already received for your condition?

Medications /____/ Surgery /____/ Physical Therapy /____/ Chiropractic /____/ None /___/ Other /____/

Name and address of other doctor(s) who have treated you for your condition:___________________________________

Date of last:		
	Physical Exam ____________________	Spinal X-ray ______________________
	Spinal Exam ____________________	Chest X-ray ______________________
	Dental X-ray ____________________	MRI/CT Scan, Bone Scan _____________

Please CIRCLE "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	Yes No	Emphysema	Yes No	Miscarriage	Yes No	Scarlet Fever	Yes No
Alcoholism	Yes No	Epilepsy	Yes No	Mononucleosis	Yes No	Stroke	Yes No
Allergy Shot	Yes No	Fractures	Yes No	M.S.	Yes No	Suicide Attempt	Yes No
Anemia	Yes No	Glaucoma	Yes No	Mumps	Yes No	Thyroid	Yes No
Anorexia	Yes No	Goiter	Yes No	Osteoporosis	Yes No	Tonsillitis	Yes No
Appendicitis	Yes No	Gonorrhea	Yes No	Pacemaker	Yes No	Tuberculosis	Yes No
Arthritis	Yes No	Gout	Yes No	Parkinson's	Yes No	Tumors	Yes No
Asthma	Yes No	Heart Disease	Yes No	Pinched Nerve	Yes No	Growths	Yes No
Bleeding	Yes No	Hepatitis	Yes No	Pneumonia	Yes No	Typhoid Fever	Yes No
Breast Lump	Yes No	Hernia	Yes No	Polio	Yes No	Ulcers	Yes No
Bronchitis	Yes No	Herniated Disc	Yes No	Prostate	Yes No	Vaginal Infections	
	Yes No						
Bulimia	Yes No	Herpes	Yes No	Prosthesis	Yes No	Venereal Disease	Yes No
Cancer	Yes No	High Cholesterol	Yes No	Psychiatric Care	Yes No	Diseases	Yes No
Cataracts	Yes No	Kidney Disease	Yes No	Rheumatoid	Yes No	Whooping Cough	Yes No
Migraines	Yes No	Liver Disease	Yes No	Measles	Yes No	Chicken Pox	Yes No
Diabetes	Yes No	Rheumatic Fever	Yes No	Chemical Dependency	Yes No	Other	Yes No

EXERCISE		WORK ACTIVITY		HABITS			
None	_____	Sitting	_____	Smoking	_____	Packs per day	_____
Moderate	_____	Standing	_____	Alcohol	_____	Drinks per week	_____
Daily	_____	Light Labor	_____	Coffee/Caffeine	_____	Cups per day	_____
Heavy	_____	Heavy Labor	_____	High Stress	_____	Reason	_____________

Are you pregnant? (Please Circle) Yes No Due Date: ____________________

Injuries/Surgeries you have had: ____ Date: _________________

Falls: ____

Head Injury: ____

Broken Bones: ____

Dislocations ____

Surgeries: ____

MEDICATIONS

Please list all medications, vitamins, herbs and minerals that you are currently taking:

____

____

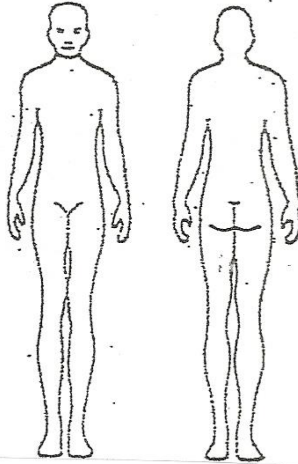
Please turn paper over and complete other side . . .

Skyline Integrated Medicine, LLC, Dr. Jennifer Fletcher DC, LAc, 0224 SW Hamilton Street, Suite 101, Portland, OR 97239
Phone: 503-222-5005 Fax: 503-222-1039

HEALTH HISTORY CONTINUED

I request services: ____Date: ________________

PATIENT CONDITION:
Reason for visit: ____
Mark an "X" on the picture (below) where you continue to have pain, numbness or tingling:



When did your symptoms first appear? ____

Is this condition getting progressively worse? (Please circle) Yes No Unknown

Type of pain: (Please circle all that apply) Sharp Dull Throbbing Numbness Aching Shooting Burning Tingling
Cramps Stiffness Swelling Other: ____________________

How often do you have this pain? ____

Is the pain consistent or does it come and go? ____

Does it interfere with your: (Please circle all that apply) Work Sleep Daily Routine Recreation

Activities or movements that are painful to perform: (Please circle all that apply) Sitting Standing Walking Bending Lying Down

NOTES:

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