



**Hoffman Chiropractic**  
 8731 Shoal Creek Blvd  
 Austin, TX 78757  
 (512) 346-5164

## CONFIDENTIAL PATIENT HISTORY

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

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

4. Have you had any previous surgeries or hospitalizations?

DATE	Reason for surgery/hospitalization	Procedure performed	Name/type of Dr.

5. What diseases such as cancer, high blood pressure, stroke, heart attack, diabetes, etc. , do family members have?

Mother \_\_\_\_\_ Grandmother \_\_\_\_\_ Sisters \_\_\_\_\_ Others \_\_\_\_\_  
 Father \_\_\_\_\_ Grandfather \_\_\_\_\_ Brothers \_\_\_\_\_

Signature (Guardian if under 18) \_\_\_\_\_ Date \_\_\_\_\_