KOZIARSKI CHIROPRACTIC
1535 W. 8TH ST
ERIE, PA 16505

GENERAL HEALTH HISTORY

Date: ___/___/___

Height: _____ **Weight: _____** **Dominate Hand:** R L (Circle One)

List current medications (RX and/or over the counter): _____
_____

Do you wear foot orthotics? Y/N
How much water do you drink each day? ( ) 0-32OZ ( ) 33-64OZ ( ) MORE THAN OZ
List any surgeries, broken bones, accidents/falls, and hospitalizations: _____

PLEASE CHECK ANY OF THE FOLLOWING YOU HAVE AHD IN THE **LAST 6 MONTHS:**

MUSCULO-SKELETAL SYSTEMS
( ) Neck Pain
( ) Upper Back Pain
( ) Mid Back Pain
( ) Low Back Pain
( ) Jaw Pain (TMJ)
( ) Shoulder Pain
( ) Elbow Pain
( ) Wrist Pain
( ) Hip Pain
( ) Thigh Pain
( ) Knee Pain
( ) Ankle Pain
( ) Foot Pain

GASTRO-INTESTINAL SYSTEMS
( ) Poor/Excessive Appetite
( ) Excessive Thirst
( ) Vomiting
( ) Diarrhea
( ) Constipation
( ) Hemorrhoids
( ) Liver Problems
( ) Gall Bladder Problems
( ) Weight Trouble
( ) Abdominal Cramps
( ) Heartburn
( ) Gas/Bloating After Meal
( ) Black Bloody Stool
( ) Colitis

Nervous System:
( ) Nervous
( ) Numbness
( ) Tingling
( ) Disorientation

GENERAL CODE:
( ) Fatigue
( ) Allergies
( ) Fever
( ) Loss of Sleep
( ) Headaches

GENITO-URINARY SYSTEM:
( ) Bladder Trouble
( ) Painful/Excessive Urination
( ) Incontinence
( )Discolored Urine
( ) Bed Wetting

C-V-R CODE:
( )Chest Pain
( ) Short Breath
( ) Blood Pressure Problems
( ) Irregular Heartbeat
( ) Heart Problems
( ) Ankle Swelling
( ) Varicose Veins
( ) Lung Problems/Congestion

MALE/FEMALE CODE:
( ) Menstrual Cramps
( ) Menstrual Irregularity
( ) Vaginal Pain/Infection
( ) Breast Pain/Lumps
( ) Prostate/Sexual Dysfunction

FEMALES ONLY:
( ) When was your last period?___
( ) Are you on Estrogen> Y?N
( ) Are you Pregnant? Y/N/ Not Sure

FAMILY HISTORY
(same or similar problem):
( )Mother ( ) Father
( ) Brother ( ) Sister
( ) Spouse ( ) Child

INTAKE (QTY):
( ) Coffee/tea___ cups per day
( ) Alcohol___ drinks per week
( ) Tobacco ___ packs per day

WORK ACTIVITY:
( ) Sitting ( ) Standing
( ) Light Labor ( ) Heavy Labor

EXERCISE:
( ) None ( ) Moderate
( ) Daily ( ) Heavy
Describe:_____
_____

Check any of the following diseases you have had:
( ) Pneumonia ( )Polio
( ) Rheumatic Fever ( ) Anemia
( ) Tuberculosis ( ) Mumps
( ) Whooping Cough ( ) C. Pox
( ) Measles ( ) Cancer
( ) Small Pox ( ) Thyroid
( ) Diabetes ( ) Pleurisy
( ) Heart Disease ( ) Epilepsy
( ) Influenza ( ) Eczema
( ) Arthritis
( ) Mental Disorders
( ) Lumbago
Have you been tested HIV +? Y/N