PATIENT MEDICAL HISTORY

Natural Health Care Alternatives, PC

Frank B. Hatch, D.C.

Patient Name:_____ Date: _____

MEDICAL HISTORY:

Please circle if **YOU** have history of or are suffering now from any of the following:

HIV/ARC/AIDS	Diabetes	Multiple Sclerosis	Thyroid
Alcoholism	Emphysema	Osteoporosis	Tumor growth
Anemia	Epilepsy	Pacemaker	Ulcers
Anorexia	Fractures	Parkinson's	Vaginal infections
Appendicitis	Heart disease	Pinched nerve	Whiplash
Arthritis	Hernia	Pneumonia	Bulimia
Asthma	Herniated disc	Polio	Chemical dependency
Bleeding Disorder	High Cholesterol	Prostate	Venereal disease
Auto Immune problems	Kidney Disease	Psychiatric	Hepatitis
Bronchitis	Liver Disease	Rheumatoid arthritis	Stroke
Cancer	Migraine headache	Depression	Suicide attempt
Miscarriage			

Please circle if your **FAMILY** has history of or are suffering now from any of the following:

HIV/ARC/AIDS	Diabetes	Multiple Sclerosis	Thyroid
Alcoholism	Emphysema	Osteoporosis	Tumor growth
Anemia	Epilepsy	Pacemaker	Ulcers
Anorexia	Fractures	Parkinson's	Vaginal infections
Appendicitis	Heart disease	Pinched nerve	Whiplash
Arthritis	Hernia	Pneumonia	Bulimia
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Bleeding Disorder	High Cholesterol	Prostate	Venereal disease
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Miscarriage			

Have you been treated by a physician for any health condition in the past year? YES NO

Describe:_____

Date of last physical exam:_____

SURGICAL HISTORY:

1. _____ Date:_____

2._____ Date:_____

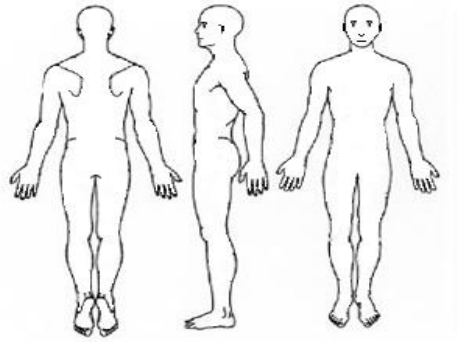
Any metal implants? YES NO Gunshot wounds? YES NO

ACCIDENT HISTORY:

Auto Job Other 1._____ Date:_____

Auto Job Other 1._____ Date:_____

Describe Major Complaints rating your symptoms on a scale of 1 to 10. 10 being the worst.



1. _____ Best: _____ Worst: _____
2. _____ Best: _____ Worst: _____
3. _____ Best: _____ Worst: _____
4. _____ Best: _____ Worst: _____
5. _____ Best: _____ Worst: _____

How much of the time do you experience symptoms? 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

Symptoms developed from: _____Work_____Auto accident_____Accident_____Illness

_____Gradual onset_____Other Date of onset:_____

Symptoms have persisted for #:_____Hours_____Days_____Weeks_____Months_____Years

Symptoms_____Come and go (or are)_____Constant

Name and location of doctors previously seen for present condition:_____

_____

_____

Are you pregnant: YES NO Date of last menstrual cycle:_____

Circle which activities **aggravate** your condition:

Bending	Reaching	Straining at stool	Coughing	Turning head
Lifting	Sneezing	Walking	Lying down	Sitting

Circle which activities **relieve** your condition:

Bending	Sitting	Lifting	Standing	Reaching
Walking	Lying down	Turning head		

Please circle any additional symptoms you might be experiencing:

Blurred Vision	Diarrhea	Insomnia	Pins/Needles in leg
Buzzing in ears	Dizziness	Light bothers eyes	Gets sick easily
Cold feet/hands	Flushed face	Loss of balance	Shortness of breath
Cold sweats	Fainting	Loss of taste	Confusion
Stiff neck	Fatigue	Muscle jerking	Pins/Needles in arm
Headaches	Fever	Constipation	Head feels heavy
Numbness in fingers	Numbness in toes	Ringing in ears	Depression/weeping