

Health History Side 2: Please complete both sides of this form
 Gardiner Family Chiropractic 90 Main Avenue, Gardiner, Me 04345 (207) 582-2222

Family History - Check all that apply:

aneurysm arthritis cancer diabetes heart disease
 high blood pressure psychiatric stroke thyroid problems
 Mother is deceased. Cause of death: _____ Father is deceased. Cause of death: : _____

Recreational Activities – Please check all that you engage in:

Aerobics Backpacking Baseball/Softball Basketball Biking
 Boating Bowling Child care Climbing stairs Cutting wood
 Dancing Exercise machines Age(s): _____ Fishing Football
 Free Weights Gardening Weight(s): _____ Golf Gymnastics
 Hockey Horse back riding Horseshoes Hunting Jogging (> a mile)
 Jogging (mile or less) Lacrosse Lawn mowing Martial arts Meditation
 Pilates Resistance training Skiing Snow shoveling Soccer
 Swimming Tennis Volleyball Walking (> a mile) Walking (mile or less)
 Water skiing Weed eater use Wrestling Yoga Other: _____

Social History - Check All That Apply:

Caffeine used often Caffeine used sometimes Drink alcohol often Drink alcohol sometimes
 Exercise not at all Exercise often Exercise sometimes
 Experience stress often Experience stress sometimes

 Chew Tobacco Often Former Smoker Never been a smoker
 Current every day smoker Current sometimes smoker Smoke 1 pack or less/day Smoke more than 1 pack/day

Level of interest in quitting smoking? (No interest) 0 1 2 3 4 5 6 7 8 9 10 (Very interested)

Life Events - Please indicate if you have experienced any of the following in the last 5 years:

Birth/adoption of a child Caregiver to family member Change in financial status
 Change in job Change in living conditions Change in residence
 Death of a family member or friend Death of a spouse Dependence problems
 Divorce Handicapped household member alcohol drugs
 Loss of job Marital separation Marriage
 Retirement

Hospitalizations		Surgeries		Year
Reason	Year			
Past History of Trauma (accidents, falls, etc)		X-rays/Imaging Studies in the Past 5 Years		
	Year	Type of study & area of body	Taken where?	Date

 **Patient Signature:** _____ **Date:** _____

This section for returning patients only	I have reviewed both sides of this sheet and have indicated any applicable changes to my health history.	
	Patient Signature: _____	Date: _____
	Patient Signature: _____	Date: _____
	Patient Signature: _____	Date: _____