Family Health History Form

Name ______________________________ **Date** ________________

It is important to read the following before filling out this form. Any and all physical events that our body goes through leaves obvious and in most cases, not so obvious findings. Therefore, it is important you take time and thoughtfully (as well as honestly) answer all the following questions. Even the ones you believe we have already verbally asked you.

1. Have you ever fractured any bones in your body at any time, ever? (Please explain each with dates.)

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2. How do you sleep?

______ Stomach	______ Very peacefully
______ Side	______ Restless
______ Back	______ Hours per night?

3. What are your favorite hobbies and activities? How often do you participate in them (times per week/ hours per time)?

____

____

4. How would you rate your energy level overall, prior to your present findings, on a scale of 0 to 10 (10 being the best)? ________________

5. Do you ever experience headaches more than *one time per year*; if so, please describe, how often, location, and duration?

____

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6. Is Mom still alive? <u>yes or no</u> Is Dad still alive? <u>yes or no</u>

6a. Please describe the reason for their passing, if applicable, or their current health status if they are living.

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____

7. Once again, describe the current problem area you have consulted us for.

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7a. When this current problem is at its absolute worst, in what ways does it interfere (reduce your productivity or effectiveness) with your daily activities?

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8. When this problem is at its absolute worst, do you feel older than you actually are? Yes / No

If yes, how much older? ____________________

9. If this problem was left unattended for another five years, how do you think it would affect you? Would it just disappear?

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10. On a scale of 1 to 10, 10 being the greatest you ever felt in your entire life, when would you say the last time that you felt a 10? What do you attribute that to?

____

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11. On that same scale, when this problem has been at its absolute worst, where would you have rated yourself? ____

12. What are your current weekly exercise habits?

____

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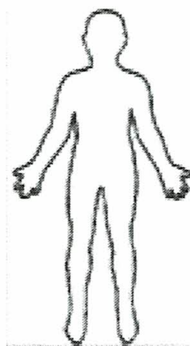
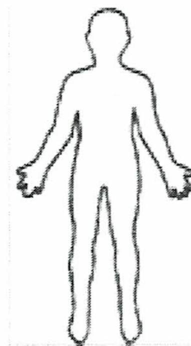
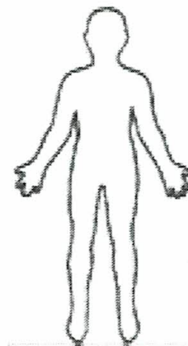
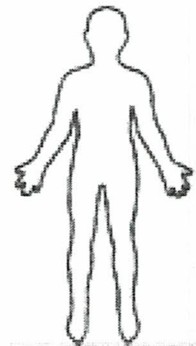
13. Below, mark the area(s) of pain describing the location as well as rating your pain (1-10) in that area with 1 being no pain and 10 being the worst pain you have ever felt.

	Front	Front	Back	Back
				
Location:	____________	____________	____________	____________
Rate your pain:	__________	__________	__________	__________