Homberg Chiropractic & Wellness
5111 Homberg Drive, Knoxville, TN 37919

Supplemental Health History

Please mark the appropriate box for any current or previous health conditions

Musculoskeletal
- ☐ Auto Accidents
- ___0-1 years ago
- ___1-5 years ago
- ___More than 5
- ☐ Fractured Bones
- ☐ Pain/Stiff Neck R L
- ☐ Upper Back Pain/Stiffness
- ☐ Mid Back Pain/Stiffness
- ☐ Numbness, Tingling or Pain in
- ☐ Numbness/Tingling/Pain Arms/Hands/Fingers R or L
- ☐ Swollen/Painful Joints
- ☐ Difficulty in Excessive Standing, Walking, Bending, Riding, Twisting, Lifting, Household Duties
- ☐ Other Accidents/Falls
- ☐ Back Curvature
- ☐ Low Back
- ☐ Shoulder Pain R / L
- ☐ Arthritis
- ☐ Jaw Pain/TMJ R / L
- ☐ Foot Trouble R / L
- ☐ Hip Pain R / L

Neurological
- ☐ Convulsions/Epilepsy
- ☐ Learning Disability
- ☐ Loss of Balance
- ☐ Dizziness
- ☐ Ringing in Ears R / L
- ☐ Trouble Concentrating
- ☐ Irritable
- ☐ Fainting
- ☐ Hearing Lost R /L
- ☐ Tremors
- ☐ Double Vision R / L
- ☐ Trouble Sleeping
- ☐ Blurred Vision R / L
- ☐ Mood Changes
- ☐ Headache
- ☐ Pain with cough, sneeze
- ☐ Depressed
- ☐ Eating Disorders

Digestive
- ☐ Diarrhea/Constipation
- ☐ Heartburn
- ☐ Colon Trouble
- ☐ Gall Bladder Trouble
- ☐ Diabetes
- ☐ Ulcers
- ☐ Hemorrhoids

Immune
- ☐ Frequent Colds/flu
- ☐ Difficulty Breathing
- ☐ Asthma
- ☐ Ear Infection
- ☐ Allergies
- ☐ Cancer (Any type/Anywhere)
- ☐ AIDS/HIV

Other Systems
- ☐ Kidney Trouble
- ☐ Chest Pain
- ☐ Lung Problems
- ☐ Heart Problems
- ☐ Liver Trouble
- ☐ High/Low Blood Pressure
- ☐ Head/Shoulders Feel Tired
- ☐ Stroke
- ☐ Anemia
- ☐ Prostate Problems
- ☐ Impotence
- ☐ Skin Problems
- ☐ Thyroid Problems
- ☐ Varicose Veins
- ☐ Bed Wetting
- ☐ Menopausal Problems
- ☐ Menstrual Problems/PMS
- ☐ Pregnant (now)
- ☐ Endometriosis
- ☐ Ovarian/Uterine Cysts

EXERCISE
- ☐ None
- ☐ Moderate
- ☐ Daily
- ☐ Heavy

Types Of Exercise: ________________________
____
____

WORK ACTIVITY
- ☐ Sitting
- ☐ Standing
- ☐ Light Labor
- ☐ Heavy Labor

HABITS
- ☐ Smoking — Packs/Day _________
- ☐ Alcohol — Dinks/week _________
- ☐ Coffee/Caffeine — Cups/Day _________
- ☐ High Stress Level — Reason ___________

ACTIVITIES OF DAILY LIVING

ACTIVITY	No Pain	Mild Pain	Tolerable Pain	Moderate Pain	Severe Pain	Disabling Pain
Walking	☐	☐	☐	☐	☐	☐
Sitting	☐	☐	☐	☐	☐	☐
Bending	☐	☐	☐	☐	☐	☐
Standing	☐	☐	☐	☐	☐	☐
Sleeping	☐	☐	☐	☐	☐	☐
Lifting	☐	☐	☐	☐	☐	☐
Running	☐	☐	☐	☐	☐	☐
Climbing Stairs	☐	☐	☐	☐	☐	☐
Carrying	☐	☐	☐	☐	☐	☐
Pushing	☐	☐	☐	☐	☐	☐
Driving	☐	☐	☐	☐	☐	☐
Dressing	☐	☐	☐	☐	☐	☐
Reading	☐	☐	☐	☐	☐	☐
Watching TV	☐	☐	☐	☐	☐	☐
Household Chore	☐	☐	☐	☐	☐	☐
Gardening	☐	☐	☐	☐	☐	☐
Sports	☐	☐	☐	☐	☐	☐
Working	☐	☐	☐	☐	☐	☐
Dancing	☐	☐	☐	☐	☐	☐
Sitting to Standing	☐	☐	☐	☐	☐	☐
Rolling Over	☐	☐	☐	☐	☐	☐
Doing Computer Work	☐	☐	☐	☐	☐	☐
Shoveling	☐	☐	☐	☐	☐	☐

The above information is true and accurate to the best of my knowledge. I clearly understand and agree that all services rendered to me may be charged directly to me and that I am directly responsible for payment

Patient or Guardian Signature: ____ Date: ______________________