



**DR. SHMUEL LUX**, Chiropractor  
 Dan Panorama Jerusalem  
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## PERSONAL HEALTH HISTORY FORM

<b>Today's Date:</b>		
<b>Name</b>	<input type="checkbox"/> M <input type="checkbox"/> F	<b>Address:</b>
<b>Birth Date:</b>	<b>Email:</b>	
<b>Cell Ph:</b>	<b>H-Ph:</b>	
<b>Marital status:</b> <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed (Spouses Name):		
<b>Occupation:</b>	<b>Employer:</b>	<b>Biz Ph:</b>
<b>Children &amp; Ages:</b>		
<b>Emergency Contact:</b>	<b>Relationship:</b>	<b>Ph:</b>
<b>Referred by:</b>		
<b>What is the purpose of your visit?</b>		
<b>Describe your condition:</b>		
<b>When did this condition start?</b>		
<b>What makes your condition worse or better?</b>		
<b>Is the pain worse at night?</b>		
<b>What are your goals with treatment?</b> <input type="checkbox"/> Temporary Relief <input type="checkbox"/> Long-term preventative care		
<b>Childhood illness:</b> <input type="checkbox"/> Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Chickenpox <input type="checkbox"/> Polio <input type="checkbox"/> Other		
<b>List prescription drugs, over-the-counter drugs, inhalers you are taking:</b>		
<b>Surgeries, serious illnesses, or cancer</b>		
<b>Have you had chiropractic treatment in the past?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes Dr. name & location:		
<b>Which vitamins, minerals and/or herbs are you taking?</b>		

<b>Exercise/Diet</b>	<i>Describe your exercise program: Are you dieting?</i>		
<b>Caffeine</b>	<input type="checkbox"/> Chocolate	<input type="checkbox"/> Coffee	<input type="checkbox"/> Tea <input type="checkbox"/> Cola
<b>Alcohol/Tobacco</b>	<i>Do you drink alcohol?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Do you use tobacco?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No		

**WOMEN ONLY:** Describe any menstrual or menopausal symptoms:

**Check if you have, or previously had, any symptoms in the following areas to a significant degree and briefly explain:**

<input type="checkbox"/> Skin	<input type="checkbox"/> Chest/Heart	<input type="checkbox"/> Other pain/discomfort
<input type="checkbox"/> Head/Neck	<input type="checkbox"/> Back	<b>Recent changes in:</b>
<input type="checkbox"/> Ears	<input type="checkbox"/> Intestinal	<input type="checkbox"/> Weight
<input type="checkbox"/> Nose	<input type="checkbox"/> Bladder/Prostate	<input type="checkbox"/> Energy level
<input type="checkbox"/> Throat	<input type="checkbox"/> Joints/Muscles	<input type="checkbox"/> Ability to sleep
<input type="checkbox"/> Lungs	<input type="checkbox"/> Circulation	

**Please provide 24-hr advance notice when cancelling an appt, so this time can be given to someone else in need of treatment**

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Signature