



Name: \_\_\_\_\_

DOB: \_\_\_\_\_

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## HEALTH HISTORY

What treatment have you already received for your condition?  Medications  Surgery  Physical Therapy

Chiropractic Services  None  Other \_\_\_\_\_

Name and address of other doctor(s) who have treated you for your condition \_\_\_\_\_

Date of Last: Physical Exam \_\_\_\_\_ Spinal X-Ray \_\_\_\_\_ Blood Test \_\_\_\_\_

Spinal Exam \_\_\_\_\_ Chest X-Ray \_\_\_\_\_ Urine Test \_\_\_\_\_

Dental X-Ray \_\_\_\_\_ MRI, CT-Scan, Bone Scan \_\_\_\_\_

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

- |                     |  |                     |  |                      |  |                              |  |
|---------------------|--|---------------------|--|----------------------|--|------------------------------|--|
| AIDS/HIV            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever              | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Alcoholism          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Emphysema           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Measles              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Scarlet Fever                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Allergy Shots       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Migraine Headaches   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sexually Transmitted Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fractures           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Miscarriage          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke                       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anorexia            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mononucleosis        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Suicide Attempt              | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Appendicitis        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Goiter              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Multiple Sclerosis   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Problems             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Gonorrhea           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mumps                | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tonsillitis                  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Gout                | <input type="checkbox"/> Yes <input type="checkbox"/> No | Osteoporosis         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis                 | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding Disorders  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Disease       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pacemaker            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tumors, Growths              | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Breast Lump         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Parkinson's Disease  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Typhoid Fever                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bronchitis          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hernia              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pinched Nerve        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcers                       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bulimia             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Herniated Disk      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pneumonia            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Vaginal Infections           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Herpes              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Polio                | <input type="checkbox"/> Yes <input type="checkbox"/> No | Whooping Cough               | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cataracts           | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Prostate Problem     | <input type="checkbox"/> Yes <input type="checkbox"/> No | Other _____                  |  |
| Chemical Dependency | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Cholesterol    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Prosthesis           | <input type="checkbox"/> Yes <input type="checkbox"/> No |                              |  |
| Chicken Pox         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Disease      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric Care     | <input type="checkbox"/> Yes <input type="checkbox"/> No |                              |  |
|                     |  |                     |  | Rheumatoid Arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No |                              |  |

### EXERCISE

- None
- Moderate
- Daily
- Heavy

### WORK ACTIVITY

- Sitting
- Standing
- Light Labor
- Heavy Labor

### HABITS

- Smoking \_\_\_\_\_ Packs/Day
- Alcohol \_\_\_\_\_ Drinks/Week
- Coffee/Caffeine Drinks \_\_\_\_\_ Cups/Day
- High Stress Level \_\_\_\_\_ Reason \_\_\_\_\_

Are you pregnant?  Yes  No Due Date \_\_\_\_\_

Injuries/Surgeries you have had	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

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## MEDICATIONS

## ALLERGIES

## VITAMINS/HERBS/MINERALS

Pharmacy Name \_\_\_\_\_

Pharmacy Phone (\_\_\_\_) \_\_\_\_\_