Health History

What treatment have you already recieved 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 __/__/__ Dental X-Ray __/__/__ Chest X-Ray __/__/__ Blood test __/__/__

Spinal Exam __/__/__ Spinal X-Ray __/__/__ MRI, CT scan, Bone scan __/__/__ Urine test __/__/__

Exercise
- ☐ None
- ☐ Moderate
- ☐ Daily
- ☐ Heavy

Work Activity
- ☐ Sitting
- ☐ Standing
- ☐ Light labor
- ☐ Heavy labor

Habits
- ☐ Smoke - pks/day_____
- ☐ Alcohol - drinks/wk _____
- ☐ Coffee/Caffeine drink - cups/day_____
- ☐ High Stress - reason____________________
- ☐ OTHER____________________

____

Are you pregnant? ☐ Yes ☐ No Due Date: __/__/__

Medications

____

____

____

Allergies

____

____

____

Vitamins, Minerals, Herbs

____

____

____

Injuries / Surgeries	**Date**	**Description**
☐ Falls	__/__/__	____________________
☐ Head Injuries	__/__/__	____________________
☐ Broken Bones	__/__/__	____________________
☐ Dislocations	__/__/__	____________________
☐ Surgeries	__/__/__	____________________

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

Condition	Yes	No
AIDS/HIV	☐ Yes	☐ No
Alcoholism	☐ Yes	☐ No
Allergy shots	☐ Yes	☐ No
Anemia	☐ Yes	☐ No
Anorexia	☐ Yes	☐ No
Appendicitis	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Bleeding disorder	☐ Yes	☐ No
Breast lump	☐ Yes	☐ No
Bronchitis	☐ Yes	☐ No
Bulimia	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
Cataracts	☐ Yes	☐ No
Chemical dependency	☐ Yes	☐ No
Chicken pox	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No
Fractures	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No
Goiter	☐ Yes	☐ No
Gonorrhea	☐ Yes	☐ No
Gout	☐ Yes	☐ No
Heart disease	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No
Hernia	☐ Yes	☐ No
Herniated disk	☐ Yes	☐ No
Herpes	☐ Yes	☐ No
High cholesterol	☐ Yes	☐ No
Kidney disease	☐ Yes	☐ No
Liver disease	☐ Yes	☐ No
Measles	☐ Yes	☐ No
Migraine headaches	☐ Yes	☐ No
Miscarriage	☐ Yes	☐ No
Mononucleosis	☐ Yes	☐ No
Multiple sclerosis	☐ Yes	☐ No
Mumps	☐ Yes	☐ No
Osteoporosis	☐ Yes	☐ No
Pacemaker	☐ Yes	☐ No
Parkinson's disease	☐ Yes	☐ No
Pinched nerve	☐ Yes	☐ No
Pneumonia	☐ Yes	☐ No
Polio	☐ Yes	☐ No
Prostrate problem	☐ Yes	☐ No
Prosthesis		
Psychiatric care	☐ Yes	☐ No
Rheumatoid Arthritis	☐ Yes	☐ No
Rheumatic fever	☐ Yes	☐ No
Scarlet fever	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Suicide Attempt	☐ Yes	☐ No
Thyroid problems	☐ Yes	☐ No
Tonsillitis	☐ Yes	☐ No
Tumors/growths	☐ Yes	☐ No
Typhoid fever	☐ Yes	☐ No
Ulcers	☐ Yes	☐ No
Vaginal infection	☐ Yes	☐ No
Venereal disease	☐ Yes	☐ No
Whooping cough	☐ Yes	☐ No

Other ____________________

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