Health History

What treatment(s) 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	[ ] Yes	[ ] No	Diabetes	[ ] Yes	[ ] No	Measles	[ ] Yes	[ ] No	Rheumatoid Arthritis	[ ] Yes	[ ] No
Alcoholism	[ ] Yes	[ ] No	Emphysema	[ ] Yes	[ ] No	Migraine Headaches	[ ] Yes	[ ] No	Rheumatic Fever	[ ] Yes	[ ] No
Allergy Shots	[ ] Yes	[ ] No	Epilepsy	[ ] Yes	[ ] No	Miscarriage	[ ] Yes	[ ] No	Scarlet Fever	[ ] Yes	[ ] No
Anemia	[ ] Yes	[ ] No	Fractures	[ ] Yes	[ ] No	Mononucleosis	[ ] Yes	[ ] No	Stroke	[ ] Yes	[ ] No
Anorexia	[ ] Yes	[ ] No	Glaucoma	[ ] Yes	[ ] No	Multiple Sclerosis	[ ] Yes	[ ] No	Suicide Attempt	[ ] Yes	[ ] No
Arthritis	[ ] Yes	[ ] No	Goiter	[ ] Yes	[ ] No	Mumps	[ ] Yes	[ ] No	Thyroid Problems	[ ] Yes	[ ] No
Asthma	[ ] Yes	[ ] No	Heart Disease	[ ] Yes	[ ] No	Osteoporosis	[ ] Yes	[ ] No	Tonsillitis	[ ] Yes	[ ] No
Bleeding Disorders	[ ] Yes	[ ] No	High Blood Pressure	[ ] Yes	[ ] No	Parkinson's Disease	[ ] Yes	[ ] No	Sexually Transmitted Disease	[ ] Yes	[ ] No
Breast Lump	[ ] Yes	[ ] No	Hepatitis	[ ] Yes	[ ] No	Pacemaker	[ ] Yes	[ ] No	Tuberculosis	[ ] Yes	[ ] No
Bronchitis	[ ] Yes	[ ] No	Hernia	[ ] Yes	[ ] No	Pinched Nerve	[ ] Yes	[ ] No	Tumors, Growths	[ ] Yes	[ ] No
Bulimia	[ ] Yes	[ ] No	Herniated Disk	[ ] Yes	[ ] No	Pneumonia	[ ] Yes	[ ] No	Typhoid Fever	[ ] Yes	[ ] No
Cancer	[ ] Yes	[ ] No	Herpes	[ ] Yes	[ ] No	Polio	[ ] Yes	[ ] No	Ulcers	[ ] Yes	[ ] No
Cataracts	[ ] Yes	[ ] No	High Cholesterol	[ ] Yes	[ ] No	Prostate Problem	[ ] Yes	[ ] No	Vaginal Infections	[ ] Yes	[ ] No
Chemical Dependency	[ ] Yes	[ ] No	Kidney Disease	[ ] Yes	[ ] No	Psychiatric Care	[ ] Yes	[ ] No	Whooping Cough	[ ] Yes	[ ] No
Chicken Pox	[ ] Yes	[ ] No	Liver Disease	[ ] Yes	[ ] No	Prosthesis	[ ] Yes	[ ] No	Other	[ ] Yes	[ ] No

_____

Work Activity

[ ] Sitting
[ ] Standing
[ ] Light Labor
[ ] Heavy Labor

Exercise

[ ] None
[ ] Moderate
[ ] Daily
[ ] Heavy

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		

Medications	Allergies	Vitamins/Herbs/Minerals
Pharmacy Name		
Pharmacy Phone ( )		