HEALTH HISTORY

What treatment have you 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 ______________________________
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Date of Last: Physical Exam ______________ Spinal X-Ray ______________ Blood Test ______________
Spinal Exam ______________ Chest X-Ray ______________ Urine Test ______________
Dental X-Ray ______________ MRI / CT ______________ Bone Scan ______________

Circle to indicate if you have had any of the following:

AIDS / HIV
Alcoholism
Allergy Shots
Anemia
Anorexia
Appendicitis
Arthritis
Asthma
Bleeding Disorders
Breast Lump
Bronchitis
Bulimia
Cancer
Cataracts
Chemical Dependency
Chicken Pox
Diabetes
Emphysema
Epilepsy
Fractures
Glaucoma
Goiter
Gonorrhea
Gout
Heart Disease
Hepatitis
Hernia
Herniated Disk
Herpes
High Blood Pressure
High Cholesterol
Kidney Disease
Liver Disease
Measles
Migraine Headaches
Miscarriage
Mononucleosis
Multiple Sclerosis
Mumps
Osteoporosis
Pacemaker
Parkinson's Disease
Pinched Nerve
Polio
Prostate Problem
Prosthesis
Psychiatric Care
Rheumatoid Arthritis
Rheumatic Fever
Scarlet Fever
Stroke
Suicide Attempt
Thyroid Problems
Tonsillitis
Tuberculosis
Tumors, Growths
Typhoid Fever
Vaginal Infections
Venereal Disease
Whooping Cough
Other ____________
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EXERCISE	WORK ACTIVITY	HABITS	FREQUENCY
☐ None	☐ Sitting	☐ Smoking	Packs / Day ____________
☐ Moderate	☐ Standing	☐ Alcohol	Drinks / Week ____________
☐ Daily	☐ Light Labor	☐ Coffee / Caffeine Drinks	Cups / Day ____________
☐ Heavy	☐ Heavy Labor	☐ High Stress Labor	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 ______________________	