

MEDICAL HISTORY

NAME _____ AGE _____ DATE OF BIRTH ___/___/___

1. What is the primary reason you are seeking our help? _____

2. Have you ever had this in the past? No Yes When? _____

3. Do you have a family history of this condition? No Yes Who? _____

4. Have you seen a chiropractor before? No Yes If so, whom? _____

5. What is the date of your last physical exam? ___/___/___

6. Please provide the name of your primary physician, and if applicable any other providers seen for this condition.

Name _____ Name _____ Name _____

Phone _____ Phone _____ Phone _____

Address _____ Address _____ Address _____

City St Zip _____ City St Zip _____ City St Zip _____

7. Please list of any prescription drugs, over the counter drugs, and nutritional supplements you are currently taking.

Med _____ Dose _____ Reason _____ Med _____ Dose _____ Reason _____

Med _____ Dose _____ Reason _____ Med _____ Dose _____ Reason _____

8. Please list any hospitalizations or surgeries you have had. (Including fractures)

_____ Date _____ Date _____
_____ Date _____ Date _____

9. Please indicate if you have had or are currently have any of the following.

Past	Present	Past	Present	Past	Present	Past	Present
___	___	___	___	___	___	___	___
osteoporosis		hypertension		dizziness		neck pain	
cancer		heart attack		fainting		mid back pain	
diabetes		stroke		epilepsy		low back pain	
arthritis		chest pains		headaches		leg pain	
asthma		high cholesterol		MS		arm pain	

10. Do you have any other known health conditions? No Yes _____

11. Please indicate if an immediate family member has had any of the following? (parents, siblings, or kids)

___cancer ___heart disease ___diabetes ___lupus ___rheumatoid arthritis

12. If female, are you pregnant? No Yes Not sure/trying Date of last period ___/___/___

13. Marital status: Single Married Divorced Widowed Separated.

14. Do you have any allergies? No Yes Please List: _____

15. Do you use tobacco? No Yes Packs of cigarettes/week___ Cans of chew/week___ For how many years?___

16. Do you consume alcohol? No Yes How many drinks per week?___

17. Do you exercise? No Yes How many times per week? Cardio___ Weights___ Other___

18. Do you have any kids? No Yes How old? _____

19. What is your occupation? _____