HEALTH HISTORY

What treatment have you already received for your condition? __medications __Surgery __Physical Therapy
__Chiropractic Services __None __Other_____

Names of other doctors 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 the following:

AIDS/HIV	__Yes __No	Diabetes	__Yes __No	Liver Disease	__Yes __No	Rheumatic Fever	__Yes __No
Alcoholism	__Yes __No	Emphysema	__Yes __No	Measles	__Yes __No	Scarlet Fever	__Yes __No
Allergy Shots	__Yes __No	Epilepsy	__Yes __No	Migraine Headaches	__Yes __No	Sexually Transmitted	
Anemia	__Yes __No	Fractures	__Yes __No	Miscarriage	__Yes __No	Disease	__Yes __No
Anorexia	__Yes __No	Glaucoma	__Yes __No	Mononucleosis	__Yes __No	Stroke	__Yes __No
Appendicitis	__Yes __No	Goiter	__Yes __No	Multiple Sclerosis	__Yes __No	Suicide Attempt	__Yes __No
Arthritis	__Yes __No	Gonorrhea	__Yes __No	Mumps	__Yes __No	Thyroid Problems	__Yes __No
Asthma	__Yes __No	Goat	__Yes __No	Osteoporosis	__Yes __No	Tonsillitis	__Yes __No
Bleeding Disorder	__Yes __No	Heart Disease	__Yes __No	Pacemaker	__Yes __No	Tuberculosis	__Yes __No
Breast Lump	__Yes __No	Hepatitis	__Yes __No	Parkinson's Disease	__Yes __No	Typhoid Fever	__Yes __No
Bronchitis	__Yes __No	Hernia	__Yes __No	Pinched Nerve	__Yes __No	Ulcers	__Yes __No
Bulimia	__Yes __No	Herniated Disc	__Yes __No	Pneumonia	__Yes __No	Vaginal Infection	__Yes __No
Cancer	__Yes __No	Herpes	__Yes __No	Polio	__Yes __No	Whooping Cough	__Yes __No
Cataract	__Yes __No	High Blood		Prostate	__Yes __No	Other _____	
Chemical	__Yes __No	Pressure	__Yes __No	Prosthesis	__Yes __No	_____	
Dependency	__Yes __No	High Cholesterol	__Yes __No	Psychiatric Care	__Yes __No	_____	

EXERCISE	WORK ACTIVITY	HABIT	
__None	__Sitting	__Smoking	Packs/Day_____
__Moderate	__Standing	__Alcohol	Drinks/Week_____
__Daily	__Light Labor	__Coffee/Caffeine	Cups/Day_____
__Heavy	__Heavy Labor	__High Stress Level	Reason_____

MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you pregnant? __Yes __No If Yes, Due Date?_____

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

FAMILY HEALTH INFORMATION

Name	Relation	Past and Present health Problems
_____	_____	_____
_____	_____	_____
_____	_____	_____

I have read and reviewed the following health information on this patient. _____
Dr.'s initials