Health History

What treatment 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:

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 Disorders	☐ 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
Prostate Problem	☐ Yes	☐ No
Prosthesis	☐ Yes	☐ No
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
Tuberculosis	☐ Yes	☐ No
Tumors, Growths	☐ Yes	☐ No
Typhoid Fever	☐ Yes	☐ No
Ulcers	☐ Yes	☐ No
Vaginal Infections	☐ Yes	☐ No
Venereal Disease	☐ Yes	☐ No
Whooping Cough	☐ Yes	☐ No

Other ____________

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EXERCISE

☐ None

☐ Moderate

☐ Daily

☐ Heavy

WORK ACTIVITY

☐ Sitting

☐ Standing

☐ Light Labor

☐ Heavy Labor

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 (_____) ____________		