

## 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 \_\_\_\_\_ Urins 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            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Chicken Pox      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatoid Arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Alcoholism          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Measles             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Allergy Shots       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Emphysema        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Migraine Headaches  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Scarlet Fever        | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Miscarriage         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke               | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anorexia            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fractures        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mononucleosis       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Suicide Attempt      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Appendicitis        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Multiple Sclerosis  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Problems     | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Göiter           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Murmps              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tonsillitis          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Gonorrhea        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Osteoporosis        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis         | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding Disorders  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Gout             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pacemaker           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tumors, Growths      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Breast Lump         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Disease    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Parkinson's Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Typhoid Fever        | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bronchitis          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pinched Nerve       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcers               | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bufimia             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hernia           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pneumonia           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Vaginal Infections   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Herniated Disk   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Polio               | <input type="checkbox"/> Yes <input type="checkbox"/> No | Venereal Disease     | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cataracts           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Herpes           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Prostate Problem    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Whooping Cough       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemical Dependency | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Cholesterol | <input type="checkbox"/> Yes <input type="checkbox"/> No | Prosthesis          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Other _____          |  |
|                     |  | Kidney Disease   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric Care    | <input type="checkbox"/> Yes <input type="checkbox"/> No |                      |  |



### EXERCISE

- None  
 Moderate  
 Daily  
 Heavy

### WORK ACTIVITY

- Sitting  
 Standing  
 Light Labor  
 Heavy Labor

### HABITS

- Smoking  
 Alcohol  
 Coffee/Caffeine Drinks  
 High Stress Level

Packs/Day \_\_\_\_\_  
 Drinks/Week \_\_\_\_\_  
 Cups/Day \_\_\_\_\_  
 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 (____) _____	_____	_____