

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:

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

<p>EXERCISE</p> <p><input type="checkbox"/> None</p> <p><input type="checkbox"/> Moderate</p> <p><input type="checkbox"/> Daily</p> <p><input type="checkbox"/> Heavy</p>	<p>WORK ACTIVITY</p> <p><input type="checkbox"/> Sitting</p> <p><input type="checkbox"/> Standing</p> <p><input type="checkbox"/> Light Labor</p> <p><input type="checkbox"/> Heavy Labor</p>	<p>HABITS</p> <p><input type="checkbox"/> Smoking Packs/Day _____</p> <p><input type="checkbox"/> Alcohol Drinks/Week _____</p> <p><input type="checkbox"/> Coffee/Caffeine Drinks Cups/Day _____</p> <p><input type="checkbox"/> High Stress Level Reason _____</p>
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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 _____	_____	_____