

# 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:

|                     |  |                  |  |                     |  |                      |  |
|---------------------|--|------------------|--|---------------------|--|----------------------|--|
| 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 | Goiter           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mumps               | <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 |
| Bulimia             | <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 (____) _____ | _____     | _____                   |