MEDICAL HISTORY

List any accidents/falls you have had through childhood (include work/auto).

1._____

2._____

3._____

4._____

List any major medical surgeries you have had.

1._____

2._____

3._____

4._____

Have you had any fractures?_____ If so, where_____

List any previous medical diagnosis and treatment you have had for this condition.

_____

What do you think has caused or aggravates this condition?

_____

What is your general state of health? (Circle one) Excellent Good Fair Poor

When was the last time you really felt good? Weeks____ Months____ Years_____

Date of last Chiropractic treatment_____

Type of treatment_____

Time under care_____

Date of last physical exam?_____What prompted exam? _____

Date of last lab work?_____ Date of last x-ray? _____Body part? _____

Name: _____ Date: _____

Do you currently take any of the following? (Indicate how many and how long)

1. Vitamins/herbs/supplements _____
2. Birth Control _____
3. Over the counter drug _____
4. Pain med/muscle relaxant _____
5. Blood pressure medicine _____
6. Insulin _____
7. Laxative _____
8. Recreational drug _____
9. Prescribed medication _____
10. Other _____

To help us understand your total health, please provide information about your family members. Many conditions are the result of hereditary weakness.

Have you or your siblings, parents, or grandparents had any of the following?

Heart disease/Attack/circulatory problems _____

Kidney disease_____ Thyroid disease _____

Cancer _____ Autoimmune disease _____

Rheumatoid Arthritis _____ other arthritis _____

Cerebral vascular disease/stroke/TIA _____

Respiratory disease/Asthma/Emphysema/Chronic Bronchitis_____

Allergies_____ Scoliosis _____

Gastrointestinal disease, Crohns, ulcers, IBS _____

Diabetes _____ High Blood Pressure_____

Mental illness or social dysfunctions, ADD, ADHD, seizure or convulsions

_____

Name: _____ Date: _____

Do you use any of the following? Check if yes

Antihistamines_____ Alcohol_____

Tobacco_____ Coffee_____

Tea_____

If answered Yes to any of the previous explain here:

_____

_____

Type of Physical Activity	Frequency	Duration	Intensity

What is your greatest health concern?

_____

_____

_____

Are there secondary concerns you have?

_____

_____

_____

List four health goals.

1._____

2._____

3._____

4._____

Name: _____ Date: _____