

# 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            | Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No         | Migraine <input type="checkbox"/> Yes <input type="checkbox"/> No             | Rheumatic Fever <input type="checkbox"/> Yes <input type="checkbox"/> No    |
| Alcoholism <input type="checkbox"/> Yes <input type="checkbox"/> No          | Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No        | Headaches <input type="checkbox"/> Yes <input type="checkbox"/> No            | Scarlet Fever <input type="checkbox"/> Yes <input type="checkbox"/> No      |
| Allergy Shots <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             |
| Anemia <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    |
| Anorexia <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   |
| Appendicitis <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        |
| Arthritis <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       |
| Asthma <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    |
| Bleeding Disorders <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      |
| Breast Lump <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             |
| Bronchitis <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 |
| Bulimia <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   |
| Cancer <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     |
| Cataracts <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 _____   |
| Chemical Dependency <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Disease <input type="checkbox"/> Yes <input type="checkbox"/> No   | Psychiatric Care <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 | _____   |
|  | Measles <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 (____) _____	_____	_____