FAMILY HISTORY

YOUR NAME _____

Physician's Name: _____ Phone # _____ Date of last visit _____

Address: _____ City, State _____ Zip _____

Please list any medications you are currently taking: _____

_____

Please list any family (genetic) health problems: (like cancer, diabetes and heart disease)

Mother _____ Father _____

Siblings: _____ Grandparents _____

MEDICAL HISTORY

Your current physical health is: __Good ___Fair ___Poor

Have you been to a Chiropractor before? ___Yes ___No
If yes, when and for what purpose _____

Name of Chiropractor _____

Do you take vitamins or minerals? ___Yes ___No
If so, please list: _____

Do you think you need to take vitamins/minerals? ___Yes ___No

Are you taking any laxatives and/or sleeping pills? ___Yes ___No
If so, how many, how often? _____

Are you under a lot of stress on a daily basis? ___Yes ___No

How long has it been since you really felt good? _____

During the day I (please circle) sit, stand, walk, desk work, Phone work, computer work, drive, mechanical work, heavy lifting.

Do you read in bed? ___Yes ___No

Is your mattress comfortable? ___Yes ___No

Are you right or left handed? ___Right ___Left

Do you smoke or use tobacco in any other form? ___Yes ___No

Have you ever been involved in a bicycle, bus, train motorcycle or car accident? ___Yes ___No
Please explain _____
_____
_____

Were you ever knocked unconscious? ___Yes ___No

Have you broken any bones? ___Yes ___No
Please explain _____
_____

Have you had any impacts, falls or jolts that you feel may have injured you? ___Yes ___No
Please explain: _____
_____

Have you had any surgeries? ___Yes ___No
Please list: _____
_____

FOR WOMEN:

Are you taking birth control pills? ___Yes ___No
Age Periods stopped and why _____
_____

Are you pregnant? ___Unsure ___Yes ___No
Are you nursing? ___Yes ___No

DO YOU HAVE OR HAVE YOU EXPERIENCED THE FOLLOWING? PLEASE CHECK ALL THAT APPLY

__Abnormal Bleeding
__Alcohol Abuse
__Allergies
__Arthritis
__Anemia
__Artificial Bones
__Artificial Joints
__Artificial Valves
__Asthma
__Blood Transfusion
__Cancer
__Chemotherapy
__Chicken Pox
__Colitis
__Congenital Heart Defect
__Depression
__Diabetes
__Difficulty Breathing
__Drug Abuse
__Emphysema
__Epilepsy
__Fainting Spells
__Fatigue
__Fever Blisters
__Glaucoma
__Gout
__Hay Fever
__Headaches
__Heart Disease/Problems
__Hemophilia
__Hepatitis
__Herpes
__High Blood Pressure
__HIV+/AIDS
__Hospitalized
__Kidney Problems
__Kidney Stones
__Leukemia
__Liver Disease/Problems
__Low Blood Pressure
__Lupus
__Migraine
__Mitral Valve Prolapse
__Obesity
__Pacemaker
__Persistent Cough
__Psychiatric Problems
__Radiation Treatment
__Rheumatic Fever
__Rheumatism
__Scarlet Fever
__Sciatica
__Scoliosis
__Seizures
__Shingles
__Sickle Cell Disease
__Sinus Problems
__Stroke
__Suicidal Thoughts
__Thyroid Problems
__Tonsillitis
__Tuberculosis (TB)
__Ulcers
__Venereal Disease
__Other _____