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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 | 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 Sclerosis <input type="checkbox"/> Yes <input type="checkbox"/> No | 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 | Mumps <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Problems <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anorexia <input type="checkbox"/> Yes <input type="checkbox"/> No | Gout <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 |
| Appendicitis <input type="checkbox"/> Yes <input type="checkbox"/> No | Gonorrhea <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 |
| Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No | Gout <input type="checkbox"/> Yes <input type="checkbox"/> No | Parkinson's Disease <input type="checkbox"/> Yes <input type="checkbox"/> No | Tumors, Growths <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 | Pinched Nerve <input type="checkbox"/> Yes <input type="checkbox"/> No | Typhoid Fever <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding Disorders <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis <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 |
| Breast Lump <input type="checkbox"/> Yes <input type="checkbox"/> No | Hernia <input type="checkbox"/> Yes <input type="checkbox"/> No | Poliio <input type="checkbox"/> Yes <input type="checkbox"/> No | Vaginal Infections <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bronchitis <input type="checkbox"/> Yes <input type="checkbox"/> No | Herniated Disk <input type="checkbox"/> Yes <input type="checkbox"/> No | Prostate Problem <input type="checkbox"/> Yes <input type="checkbox"/> No | Venereal Disease <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bulimia <input type="checkbox"/> Yes <input type="checkbox"/> No | Herpes <input type="checkbox"/> Yes <input type="checkbox"/> No | Prosthesis <input type="checkbox"/> Yes <input type="checkbox"/> No | Whooping Cough <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No | High Cholesterol <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric Care <input type="checkbox"/> Yes <input type="checkbox"/> No | Other _____ |
| Cataracts <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Disease <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatoid Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Chemical Dependency <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Chicken Pox <input type="checkbox"/> Yes <input type="checkbox"/> No | Measles <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No | Migraine Headaches <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

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

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MEDICATIONS

ALLERGIES

VITAMINS/HERBS/MINERALS

Pharmacy Name _____ Pharmacy Phone _____		
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