PERSONAL HISTORY

DATE: _____

NAME: _____ DOB: _____ AGE: _____ SS #: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE: Cell _____ Home _____ EMAIL: _____

EMPLOYER: _____ Phone _____ TYPE OF WORK: _____

CIRCLE ONE: Married Single Divorced Widowed Separated NUMBER OF CHILDREN: _____

EMERGENCY CONTACT: Name _____ Number _____

REFERRED TO THIS OFFICE BY: _____

WHO IS RESPONSIBLE FOR YOUR BILL (circle one): Self Spouse Medicare Personal Health Ins. Other_____

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CURRENT HEALTH CONDITION

PURPOSE OF THIS VISIT: Wellness-Based ( ) or Symptom-Based ( ) Explain: _____

_____

WHEN DID THIS CONDITION BEGIN: _____ OTHER DOCTORS SEEN: _____

WHAT ARE YOUR MOST PRESSING HEALTH CONCERNS: _____

_____

FOR HOW LONG: _____

IS IT (circle one): getting worse improving constant intermittent can't say

DRUGS YOU ARE TAKING NOW: _____

VITAMINS YOU TAKE REGULARLY: _____

CURRENT LEVEL OF STRESS (circle one): minimal 1 2 3 4 5 6 7 8 9 10 maximum

RECENT FOREIGN TRAVEL (circle one): No Yes (explain) _____

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PAST HEALTH HISTORY

Please circle/describe: MAJOR SURGERY: Appendectomy Tonsillectomy Gall Bladder Broken Bones
Other _____

MAJOR ACCIDENTS/FALLS/CONCUSSIONS: _____

HOSPITALIZATIONS: _____

PREVIOUS CHIROPRACTIC CARE: ( ) None ( ) Doctor's Name & When Seen _____

HEALTH HISTORY

Do you have, or have you had, any of the following (please check all that apply):

____pneumonia	____mumps	____influenza	____rheumatic fever	____smallpox
____pleurisy	____polio	____chicken pox	____thyroid disease	____diabetes
____epilepsy	____cancer	____depression	____whooping cough	____anemia
____eczema	____measles	____arthritis	____heart disease	____rashes

If you have ever been diagnosed with another disease or condition, please describe: _____

_____

Do you use (please check all that apply):

____coffee ____tea ____alcohol ____cigarettes ____artificial sweeteners ____sugar ____recreational drugs

Have you ever suffered from (please check all that apply):

____neck pain	____stuffy nose	____discolored urine
____low back pain	____allergies	____gas/bloating after meals
____headaches	____fainting	____heartburn
____migraines	____weight loss	____colitis
____arm/back tingling	____poor appetite	____irritable bowel
____shoulder pain	____excessive appetite	____black/bloody stools
____hand pain/tingling	____nervousness	____constipation
____leg pain/tingling	____confusion	____hemorrhoids
____jaw pain	____depression	____liver problems
____chest pain	____dental problems	____stroke
____lung problems	____excessive thirst	____paralysis
____heart problems	____frequent nausea	____tingling
____abnormal blood pressure	____vomiting	____numbness
____irregular heartbeat	____prostate problem	____fatigue
____ankle swelling	____breast pain/lump	____dizziness
____cold extremities	____cramps	____loss of sleep
____blurred vision	____painful urination	____difficulty hearing
____vision problems	____bladder trouble	____ear pain
____difficulty breathing	____excessive urination	

If applicable, date of last menstrual period _____

Past injuries can affect present health. Please check all that apply:

____falls/accidents	____head injuries	____fights
____sports injuries	____broken bones	____dislocations
____spinal tap	____surgery	____traction
____use(d) a cane/walker	____extensive dental work	____dental appliances
____knocked unconscious		

If yes to any of the above, please describe: _____

_____