



## HEALTH HISTORY

What treatment have you already received for your condition?  Medications  Surgery  Physical Therapy  
 Chiropractic Services  None  Other: \_\_\_\_\_

Name & address of other doctor(s) who have treated you for this 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 ever 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	MS	<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	
Anorexia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Goiter	<input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Appendicitis	<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	Tonsilitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Parkinson's		Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumor,	
Bleeding Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hernia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pinched Nerve	<input type="checkbox"/> Yes <input type="checkbox"/> No	Growth	<input type="checkbox"/> Yes <input type="checkbox"/> No
Breast Lump	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herniated Disc	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pneumonia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Typhoid Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bronchitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Polio	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bulimia	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prostate		Vaginal	
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Problem	<input type="checkbox"/> Yes <input type="checkbox"/> No	Infections	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cataracts	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prosthesis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Veneral	
Chemical		Measles	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No	Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	Migraine		Rheumatoid		Whooping	
Chicken Pox	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No			Rheumatic		OTHER _____	
				Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	

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

MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS
_____	_____	_____
_____	_____	_____
_____	_____	_____