# 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 | ☐ Yes | ☐ No | Chicken Pox | ☐ Yes | ☐ No | Liver Disease | ☐ Yes | ☐ No | Psychiatric Care | ☐ Yes | ☐ No |
| Alcoholism | ☐ Yes | ☐ No | Diabetes | ☐ Yes | ☐ No | Measles | ☐ Yes | ☐ No | Rheumatoid Arthritis | ☐ Yes | ☐ No |
| Allergy Shots | ☐ Yes | ☐ No | Emphysema | ☐ Yes | ☐ No | Migraine Headaches | ☐ Yes | ☐ No | Rheumatic Fever | ☐ Yes | ☐ No |
| Anemia | ☐ Yes | ☐ No | Epilepsy | ☐ Yes | ☐ No | Miscarriage | ☐ Yes | ☐ No | Scarlet Fever | ☐ Yes | ☐ No |
| Anorexia | ☐ Yes | ☐ No | Fractures | ☐ Yes | ☐ No | Mononucleosis | ☐ Yes | ☐ No | Stroke | ☐ Yes | ☐ No |
| Appendicitis | ☐ Yes | ☐ No | Glaucoma | ☐ Yes | ☐ No | Multiple Sclerosis | ☐ Yes | ☐ No | Suicide Attempt | ☐ Yes | ☐ No |
| Arthritis | ☐ Yes | ☐ No | Goiter | ☐ Yes | ☐ No | Mumps | ☐ Yes | ☐ No | Thyroid Problems | ☐ Yes | ☐ No |
| Asthma | ☐ Yes | ☐ No | Gonorrhea | ☐ Yes | ☐ No | Osteoporosis | ☐ Yes | ☐ No | Tonsillitis | ☐ Yes | ☐ No |
| Bleeding Disorders | ☐ Yes | ☐ No | Gout | ☐ Yes | ☐ No | Pacemaker | ☐ Yes | ☐ No | Tuberculosis | ☐ Yes | ☐ No |
| Breast Lump | ☐ Yes | ☐ No | Heart Disease | ☐ Yes | ☐ No | Parkinson's Disease | ☐ Yes | ☐ No | Tumors, Growths | ☐ Yes | ☐ No |
| Bronchitis | ☐ Yes | ☐ No | Hepatitis | ☐ Yes | ☐ No | Pinched Nerve | ☐ Yes | ☐ No | Typhoid Fever | ☐ Yes | ☐ No |
| Bulimia | ☐ Yes | ☐ No | Hernia | ☐ Yes | ☐ No | Pneumonia | ☐ Yes | ☐ No | Ulcers | ☐ Yes | ☐ No |
| Cancer | ☐ Yes | ☐ No | Herniated Disk | ☐ Yes | ☐ No | Polio | ☐ Yes | ☐ No | Vaginal Infections | ☐ Yes | ☐ No |
| Cataracts | ☐ Yes | ☐ No | Herpes | ☐ Yes | ☐ No | Prostate Problem | ☐ Yes | ☐ No | Venereal Disease | ☐ Yes | ☐ No |
| Chemical Dependency | ☐ Yes | ☐ No | High Cholesterol | ☐ Yes | ☐ No | Prosthesis | ☐ Yes | ☐ No | Whooping Cough | ☐ Yes | ☐ No |
| | | | Kidney Disease | ☐ Yes | ☐ No | | | | Other | _____ | |

## EXERCISE

☐ None
☐ Moderate
☐ Daily
☐ Heavy

## WORK ACTIVITY

☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

## HABITS

☐ Smoking Packs/Day _____
☐ Alcohol Drinks/Week _____
☐ Coffee/Caffeine Drinks Cups/Day _____
☐ High Stress Level 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 (____) _____ | | |