## HEALTH HISTORY

What treatment have you already received for your condition? __medications __Surgery __Physical Therapy
__Chiropractic Services __None __Other_____

Names of other doctors 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 the following:

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| AIDS/HIV | __Yes __No | Diabetes | __Yes __No | Liver Disease | __Yes __No | Rheumatic Fever | __Yes __No |
| Alcoholism | __Yes __No | Emphysema | __Yes __No | Measles | __Yes __No | Scarlet Fever | __Yes __No |
| Allergy Shots | __Yes __No | Epilepsy | __Yes __No | Migraine Headaches | __Yes __No | Sexually Transmitted | |
| Anemia | __Yes __No | Fractures | __Yes __No | Miscarriage | __Yes __No | Disease | __Yes __No |
| Anorexia | __Yes __No | Glaucoma | __Yes __No | Mononucleosis | __Yes __No | Stroke | __Yes __No |
| Appendicitis | __Yes __No | Goiter | __Yes __No | Multiple Sclerosis | __Yes __No | Suicide Attempt | __Yes __No |
| Arthritis | __Yes __No | Gonorrhea | __Yes __No | Mumps | __Yes __No | Thyroid Problems | __Yes __No |
| Asthma | __Yes __No | Goat | __Yes __No | Osteoporosis | __Yes __No | Tonsillitis | __Yes __No |
| Bleeding Disorder | __Yes __No | Heart Disease | __Yes __No | Pacemaker | __Yes __No | Tuberculosis | __Yes __No |
| Breast Lump | __Yes __No | Hepatitis | __Yes __No | Parkinson's Disease | __Yes __No | Typhoid Fever | __Yes __No |
| Bronchitis | __Yes __No | Hernia | __Yes __No | Pinched Nerve | __Yes __No | Ulcers | __Yes __No |
| Bulimia | __Yes __No | Herniated Disc | __Yes __No | Pneumonia | __Yes __No | Vaginal Infection | __Yes __No |
| Cancer | __Yes __No | Herpes | __Yes __No | Polio | __Yes __No | Whooping Cough | __Yes __No |
| Cataract | __Yes __No | High Blood | | Prostate | __Yes __No | Other _____ | |
| Chemical | __Yes __No | Pressure | __Yes __No | Prosthesis | __Yes __No | _____ | |
| Dependency | __Yes __No | High Cholesterol | __Yes __No | Psychiatric Care | __Yes __No | _____ | |

| EXERCISE | WORK ACTIVITY | HABIT | |
|---|---|---|---|
| __None | __Sitting | __Smoking | Packs/Day_____ |
| __Moderate | __Standing | __Alcohol | Drinks/Week_____ |
| __Daily | __Light Labor | __Coffee/Caffeine | Cups/Day_____ |
| __Heavy | __Heavy Labor | __High Stress Level | Reason_____ |

| MEDICATIONS | ALLERGIES | VITAMINS/HERBS/MINERALS |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Are you pregnant? __Yes __No If Yes, Due Date?_____

| Injuries you have had | Description | Date |
|---|---|---|
| Falls | _____ | _____ |
| Head Injuries | _____ | _____ |
| Broken Bones | _____ | _____ |
| Dislocations | _____ | _____ |
| Surgeries | _____ | _____ |

### FAMILY HEALTH INFORMATION

| Name | Relation | Past and Present health Problems |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

I have read and reviewed the following health information on this patient. _____
Dr.'s initials