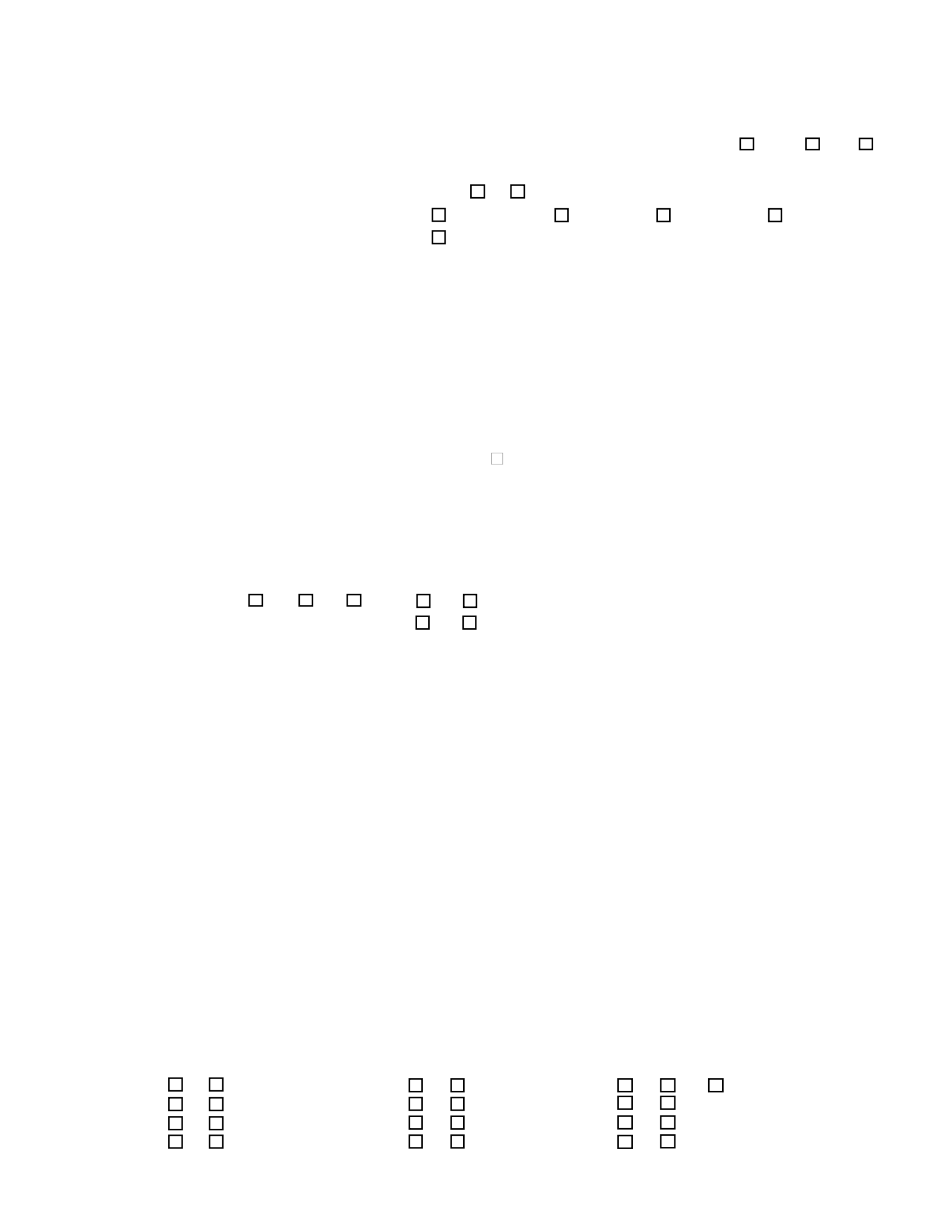

5 Medical History

Name and address of other doctor(s):

Date of Last: Physical Exam _____ Spinal X-ray _____ Spinal Exam _____ Chest X-ray _____

MRI, CT-Scan, Bone Scan _____ Blood Test _____ Urine Test _____

Mark "Yes" or "No" to indicate whether you have experienced each of the following and complete the information below:

AIDS/ HIV	☐Yes ☐No	Chemical Depend./ Alchoholism	☐Yes ☐No	Hernia	☐Yes ☐No	**Pinched Nerve**	☐Yes ☐No
Allergies	☐Yes ☐No	**Herniated Disk**	☐Yes ☐No	Pneumonia	☐Yes ☐No		
Anemia	☐Yes ☐No	Chicken Pox	☐Yes ☐No	Hypertension	☐Yes ☐No	Prostate Problem	☐Yes ☐No
Anxiety/ Depression	☐Yes ☐No	**Clotting Disorder**	☐Yes ☐No	Kidney Disease	☐Yes ☐No	Psychiatric Care	☐Yes ☐No
Appendicitis	☐Yes ☐No	Diabetes	☐Yes ☐No	Liver Disease	☐Yes ☐No	Rheum. Arthritis	☐Yes ☐No
Arthritis	☐Yes ☐No	Eating Disorder	☐Yes ☐No	Migraines	☐Yes ☐No	STD	☐Yes ☐No
Asthma	☐Yes ☐No	Emphysema	☐Yes ☐No	Mononucleosis	☐Yes ☐No	Stroke	☐Yes ☐No
Autoimmune Dis.	☐Yes ☐No	**Epilepsy/ Seizure Dis.**	☐Yes ☐No	**MS**	☐Yes ☐No	Thyroid Disease	☐Yes ☐No
Bleeding Disorder	☐Yes ☐No	Headaches	☐Yes ☐No	Osteoporosis	☐Yes ☐No	Tuberculosis	☐Yes ☐No
Bronchitis	☐Yes ☐No	Heart Disease	☐Yes ☐No	Pacemaker	☐Yes ☐No	Tumors, Growths	☐Yes ☐No
Cancer	☐Yes ☐No	Hepatitis	☐Yes ☐No	Parkinson's	☐Yes ☐No	Ulcers	☐Yes ☐No

Are you pregnant? ☐Yes ☐No If yes, how many weeks? _____ ☐Other _____

6 Motor Vehicle Accident ☐Denied

Please indicate any motor vehicle accidents below, making sure to note any minor accidents or those that have taken place 5+ years ago.

Date of Accident (MO - YR): ____ - ____

Impact: ☐Front ☐Rear ☐Side/ Passenger ☐Side/ Driver ☐Seat Belt ☐Airbag(s)

Speed at which your car was traveling: _____

Speed at which the second car struck your car: _____

Medical Care Description:

Chiropractic Care Description:

7 Motor Vehicle Accident ☐Denied

Please indicate any motor vehicle accidents below, making sure to note any minor accidents or those that have taken place 5+ years ago.

Date of Accident (MO - YR): ____ - ____

Impact: ☐Front ☐Rear ☐Side/ Passenger ☐Side/ Driver ☐Seat Belt ☐Airbag(s)

Speed at which your car was traveling: _____

Speed at which the second car struck your car: _____

Medical Care Description:

Chiropractic Care Description:

8 Physical & Trauma Information

Please indicate any physical and/ or trauma occurences below, making sure to note any minor injuries as well by checking 'Yes'. Please describe when applicable.

Work Activities: ☐Sitting ☐Standing ☐Light Labor ☐Heavy Labor ☐Retired _____

Work Injuries: ☐Yes ☐No If yes: _____

Sport Activities: _____

Sport Injuries: ☐Yes ☐No If yes: _____

Exercise: ☐None ☐Light ☐Moderate ☐Heavy _____

Home Injuries: ☐Yes ☐No If yes: _____

Habits: ☐Nicotine ☐Alcohol ☐Coffee/ Caffeine Drinks ☐High Stress Level ☐None

How Much? _____ How Often? ☐Daily ☐Weekly ☐Occasionally

Falls: ☐Yes ☐No If yes: _____

Head Injuries: ☐Yes ☐No If yes: _____

Dislocations: ☐Yes ☐No If yes: _____

Broken Bones: ☐Yes ☐No If yes: _____

Surgeries: ☐Yes ☐No If yes: _____

Your Birth Delivery: ☐Vaginal ☐Cesarean ☐Unknown

Complications: ☐Breech ☐Fetal Distress ☐CPD ☐Placenta Previa ☐Premature ☐Umbilical Cord ☐Meconium Aspiration ☐None