Medical History Information

Last Name: _____ Age: _____ Single / Mar / Div / Widow ○ ○ ○ ○

First Name: _____ Middle Initial: _____

What Do You Prefer To Be Called? _____ SS # _____

Email: _____ DOB _____

Cell # _____ Ins Company Name: _____

Member ID#: _____

Newsletters and Reminder Appts via email/text ok? Yes ○ No ○

Address: _____ City: _____ State: _____ Zip Code _____

Occupation: _____ Employer: _____ WRK# _____

Reason For Today's Visit (Chief Complaint) _____

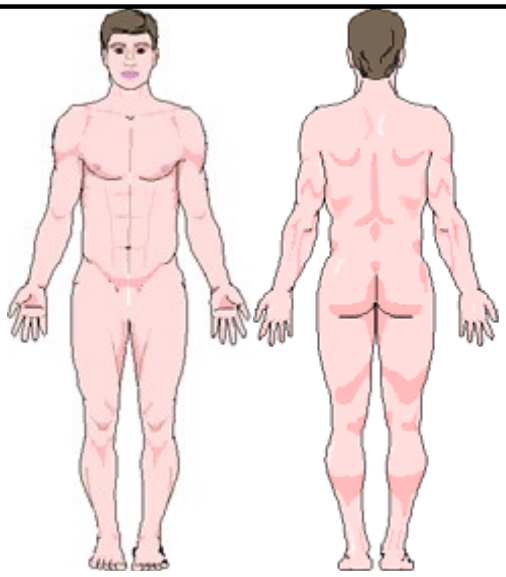
LIST AND MARK THE SEVERITY OF YOUR CONDITION ON THE SCALES BELOW

BODY PART _____ _____

0(NONE) 5 (SEVERE) 10

BODY PART _____ _____

0(NONE) 5 (SEVERE)10



When Did Your Condition First Appear?
(Specific date, days, etc).

Do You Have a **Primary Care Physician**? ☐ Yes ☐ No Name of Doctor:

Address: City: State: ZIP

Have You Ever Been Treated By A Chiropractor? ☐ Yes ☐ No **If Yes** Dr.'s Name?_____

Reason For Treatment? Last Visit?

List **ANY and ALL** Past Accidents (**even if not injured**) With Date:

Please list **ANY and ALL SURGERIES** Including Dates:

FOR WOMEN ONLY

Are you pregnant? ☐ Yes ☐ No **Due Date**?_____ Nursing? ☐ Yes ☐ No

Are you taking Birth Control? ☐ Yes ☐ No **1st date of last Menstrual cycle**

Your Current illness /Conditions:

☐ Allergies	☐ Cancer	☐ Epilepsy	☐ Low Blood Pressure	☐ Sinus Trouble
☐ Anemia	☐ Cirrhosis/Hepatitis	☐ Hay Fever	☐ Multiple Sclerosis	☐ Spinal Disc Disease
☐ Anxiety	☐ Depression	☐ Heart Problem	☐ Pacemaker	☐ STD'S
☐ Arthritis	☐ Diabetes	☐ High blood pressure	☐ Polio	☐ Thyroid trouble
☐ Asthma	☐ Dislocated joints	☐ HIV/ARC	☐ Prostate trouble	☐ Tuberculosis
☐ Bone fracture	☐ Diverticulitis	☐ Kidney trouble	☐ Scoliosis	☐ Ulcer

Other:

Family History: **Mother/ Father/ Sister/ Brother**

☐ Allergies	☐ Cancer	☐ Epilepsy	☐ Multiple Sclerosis	☐ Sinus trouble
☐ Anemia	☐ Cirrhosis/hepatitis	☐ Heart Problem	☐ Pacemaker	☐ Spinal Disc Disease
☐ Anxiety	☐ Depression	☐ High blood pressure	☐ Polio	☐ Thyroid trouble
☐ Arthritis	☐ Diabetes	☐ Kidney trouble	☐ Prostate trouble	☐ Tuberculosis
☐ Asthma	☐ Diverticulitis	☐ Low Blood Pressure	☐ Scoliosis	☐ Ulcer

Other:

Social History:

Alcohol? ☐ No ☐ Yes Drinks per week?	Cigarettes? ☐ No ☐ Yes Packs per day?	Caffeine? ☐ No ☐ Yes Drinks per day?

Exercise? ☐ No ☐ Yes Hours per week? Light ◯ Moderate ◯ Strenuous ◯

Please list ANY and ALL PRESCRIPTION medications:

ANY and ALL OVER THE COUNTER medications, vitamins & supplements:

Patient Signature Date

This Office Provides Services in Addition to Conventional Chiropractic Treatment.
Please Indicate Your Interest in The Following By Placing a Check in The Appropriate Box.

SERVICE	INTERESTED	NOT INTERESTED	WOULD LIKE TO DISCUSS WITH DR
ACUPUNCTURE			
ALTERNATIVE MEDICINE			
BODY PURIFICATION/DETOX PROGRAMS			
CARPAL TUNNEL-NON SURGICAL TREATMENTS			
COLD LASER THERAPY			
HEADACHE/MIGRAINE-NATURAL SOLUTIONS			
MASSAGE and NEUROMUSCULAR THERAPY			
NUTRITIONAL HEALTH ASSESMENT			
SPINAL DECOMPRESSION			

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.