HEALTH HISTORY

What treatment have you already received for your condition?

Medications _____ Surgery _____ Physical Therapy _____ Chiropractic Services _____ None _____

Other _____

Name and address of other Dr(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 any of the following:

Aids/HIV	Yes ___	No___	Chicken Pox	Yes___	No___	Liver Disease	Yes___	No___	Rheumatoid Arthritis	Yes___	No___
Alcoholism	Yes ___	No___	Diabetes	Yes___	No___	Measeles	Yes___	No___	Rheumatic Fever	Yes___	No___
Allergy Shots	Yes ___	No___	Emphysema	Yes___	No___	Migraine Headaches	Yes___	No___	Scarlet Fever	Yes___	No___
Anemia	Yes ___	No___	Epilepsy	Yes___	No___	Miscarriage	Yes___	No___	Stroke	Yes___	No___
Anorexia	Yes ___	No___	Fractures	Yes___	No___	Mononucleosis	Yes___	No___	Suicide Attempt	Yes___	No___
Appendicitis	Yes ___	No___	Glaucoma	Yes___	No___	Multiple Sclerosis	Yes___	No___	Thyroid Problems	Yes___	No___
Arthritis	Yes ___	No___	Goiter	Yes___	No___	Mumps	Yes___	No___	Tonsillitis	Yes___	No___
Asthma	Yes ___	No___	Gonorrhea	Yes___	No___	Osteoporosis	Yes___	No___	Tuberculosis	Yes___	No___
Bleeding Disorders	Yes ___	No___	Gout	Yes___	No___	Pacemaker	Yes___	No___	Tumors, Growths	Yes___	No___
Breast Lump	Yes ___	No___	Heart Disease	Yes___	No___	Parkinson's Disease	Yes___	No___	Typhoid Fever	Yes___	No___
Bronchitis	Yes ___	No___	Hepatitis	Yes___	No___	Pinched Nerve	Yes___	No___	Ulcers	Yes___	No___
Bullimia	Yes ___	No___	Hernia	Yes___	No___	Pnuemonia	Yes___	No___	Vaginal Infections	Yes___	No___
Cancer	Yes ___	No___	Herniated Disk	Yes___	No___	Polio	Yes___	No___	Venereal Disease	Yes___	No___
Cataracts	Yes ___	No___	Herpes	Yes___	No___	Prostrate Problem	Yes___	No___	Whooping Cough	Yes___	No___
Chemical	Yes ___	No___	High Cholesterol	Yes___	No___	Prosthesis	Yes___	No___	Other_____	Yes___	No___
Dependency	Yes ___	No___	Kidney Disease	Yes___	No___	Psychiatric Care	Yes___	No___	_____	Yes___	No___

Exercise			**Work Activity**			**Habits**			
None	Yes___	No___	Sitting	Yes___	No___	Smoking	Yes___	No___	Packs Per Day _____
Moderate	Yes___	No___	Standing	Yes___	No___	Alcohol	Yes___	No___	Drinks/Weekly _____
Daily	Yes___	No___	Light Labor	Yes___	No___	Coffee/Caffeine	Yes___	No___	Cups/Daily _____
Heavy	Yes___	No___	Heavy Labor	Yes___	No___	High Stress Level	Yes___	No___	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**