HEALTH HISTORY

Name Date

What treatment have you already received for your condition? Medications Surgery Chiropractic Physical Therapy None
Other_____
Name of other doctor (s) who have treated you for your condition_____
Date of last: **Physical Exam**_____ X-rays_____ Blood Test_____
MRI, CT-Scan, Bone Scan_____ Urine Test _____
Place a circle on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	Yes	No	Diabetes	Yes	No	Mononucleosis	Yes	No	Rheumatoid Arthritis	Yes	No
Alcoholism	Yes	No	Emphysema	Yes	No	Multiple Sclerosis	Yes	No	Rheumatic Fever	Yes	No
Allergy Shots	Yes	No	Epilepsy	Yes	No	Mumps	Yes	No	Scoliosis	Yes	No
Anemia	Yes	No	Fractures	Yes	No	Osteoporosis	Yes	No	Stroke	Yes	No
Anorexia	Yes	No	Glaucoma	Yes	No	Pacemaker	Yes	No	Thyroid Problem	Yes	No
Appendicitis	Yes	No	Goiter	Yes	No	Parkinson's Disease	Yes	No	Tuberculosis	Yes	No
Arthritis	Yes	No	Gout	Yes	No	Pinched Nerve	Yes	No	Tumors, Growth's	Yes	No
Asthma	Yes	No	Heart Disease	Yes	No	Pneumonia	Yes	No	Typhoid Fever	Yes	No
Bleeding Disorders	Yes	No	Hepatitis	Yes	No	Polio	Yes	No	Ulcers	Yes	No
Breast Lump	Yes	No	Hernia	Yes	No	Prostate Problem	Yes	No	Whooping Cough	Yes	No
Bronchitis	Yes	No	Herniated Disk	Yes	No	Prosthesis	Yes	No			
Cancer	Yes	No	High Cholesterol	Yes	No	Psychiatric Care	Yes	No			
Cataracts	Yes	No	Kidney Disease	Yes	No	PMS	Yes	No			
Chemical Dependency	Yes	No	Liver Disease	Yes	No						
Chicken Pox	Yes	No	Measles	Yes	No						
			Migraine Headache	Yes	No						

Other_____
***Family Health History (Who in your family has any disease or health problems?) Grandparents_____**
Parents_____ Siblings_____

EXERCISE
- ☐ None
- ☐ Moderate
- ☐ Daily

WORK ACTIVITY
- ☐ Sitting
- ☐ Standing
- ☐ Light Labor
- ☐ Heavy Labor

HABITS
- ☐ Smoking Packs/Day_____
- ☐ Alcohol DrinksWeek_____
- ☐ Coffee/Caffeine Cups/Day_____
- ☐ High Stress Level Reason_____

Are you pregnant? Yes No Due Date_____ Do you have children? Yes No How Many?_____

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS
Pharmacy Name_____		
Pharmacy Phone_____		