

## Health History

Are you currently receiving treatment for any healthcare conditions?  Medications  Surgery  Physical Therapy  
 Chiropractic  None  Other \_\_\_\_\_

Name and location of other doctor(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 \_\_\_\_\_

Are you pregnant?  Yes  No Due Date \_\_\_\_\_

Place a mark to indicate if you have had any of the following:

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> AIDS/HIV            | <input type="checkbox"/> Chicken Pox      | <input type="checkbox"/> Liver Disease       | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Alcoholism          | <input type="checkbox"/> Diabetes         | <input type="checkbox"/> Measles             | <input type="checkbox"/> Rheumatic Fever      |
| <input type="checkbox"/> Allergy Shots       | <input type="checkbox"/> Emphysema        | <input type="checkbox"/> Migraines           | <input type="checkbox"/> Scarlet Fever        |
| <input type="checkbox"/> Anemia              | <input type="checkbox"/> Epilepsy         | <input type="checkbox"/> Miscarriage         | <input type="checkbox"/> Stroke               |
| <input type="checkbox"/> Anorexia            | <input type="checkbox"/> Fractures        | <input type="checkbox"/> Mononucleosis       | <input type="checkbox"/> Suicide Attempt      |
| <input type="checkbox"/> Appendicitis        | <input type="checkbox"/> Glaucoma         | <input type="checkbox"/> Multiple Sclerosis  | <input type="checkbox"/> Thyroid Problem      |
| <input type="checkbox"/> Arthritis           | <input type="checkbox"/> Goiter           | <input type="checkbox"/> Mumps               | <input type="checkbox"/> Tonsillitis          |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Gonorrhea        | <input type="checkbox"/> Osteoporosis        | <input type="checkbox"/> Tuberculosis         |
| <input type="checkbox"/> Bleeding Disorders  | <input type="checkbox"/> Gout             | <input type="checkbox"/> Pacemaker           | <input type="checkbox"/> Tumor, Growth        |
| <input type="checkbox"/> Breast Lump         | <input type="checkbox"/> Heart Disease    | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Typhoid Fever        |
| <input type="checkbox"/> Bronchitis          | <input type="checkbox"/> Hepatitis        | <input type="checkbox"/> Pinched Nerve       | <input type="checkbox"/> Ulcers               |
| <input type="checkbox"/> Bulimia             | <input type="checkbox"/> Hernia           | <input type="checkbox"/> Pneumonia           | <input type="checkbox"/> Vaginal Infection    |
| <input type="checkbox"/> Cancer              | <input type="checkbox"/> Herniated Disc   | <input type="checkbox"/> Polio               | <input type="checkbox"/> Venereal Disease     |
| <input type="checkbox"/> Cataracts           | <input type="checkbox"/> Herpes           | <input type="checkbox"/> Prostate Problem    | <input type="checkbox"/> Whooping Cough       |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Prosthesis          |   |
|  | <input type="checkbox"/> Kidney Disease   | <input type="checkbox"/> Psychiatric Care    |   |
| <input type="checkbox"/> Other _____         |   |  |   |

### Exercise

- None  
 Moderate  
 Daily  
 Heavy

### Work Activity

- Sitting  
 Standing  
 Light Labor  
 Heavy Labor

### Habits

- Smoking Packs/day \_\_\_\_\_  
 Alcohol Drinks/week \_\_\_\_\_  
 Coffee/Caffeine Cups/day \_\_\_\_\_  
 High Stress Level Cause \_\_\_\_\_

*Injuries/Surgeries you have had*

Description	Date
Falls _____	_____
Head Injuries _____	_____
Broken Bones _____	_____
Dislocations _____	_____
Surgeries _____	_____

## Medications

### Medications

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### Allergies

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### Vitamins/Herbs/Minerals

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Pharmacy Name \_\_\_\_\_

Pharmacy Phone \_\_\_\_\_