Patient History

Patient Name ______________________ Date ____________

Check the box next to any condition you have experienced:

Conditions

- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Allergy Shots
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bladder Trouble
- ☐ Bleeding Disorders
- ☐ Blurred Vision
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Buzzing in Ears
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chest Pain
- ☐ Concentration Loss
- ☐ Concussion
- ☐ Confusion
- ☐ Convulsions
- ☐ Constipation
- ☐ Depression (Chronic)
- ☐ Diabetes
- ☐ Diarrhea (Chronic)
- ☐ Dislocated Joints
- ☐ Diverticuli
- ☐ Dizziness
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting
- ☐ Fatigue (chronic)
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Headaches
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herniated Disc
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ IBS
- ☐ Indigestion
- ☐ Insomnia
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraines
- ☐ Miscarriages
- ☐ Mono
- ☐ Mumps
- ☐ Multiple Sclerosis
- ☐ Muscle Cramps
- ☐ Muscle Spasms
- ☐ Nervousness
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Parkinson's
- ☐ Pinched Nerve
- ☐ Pneumonia
- ☐ Poor Circulation
- ☐ Prostate Problem
- ☐ Prosthesis
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Sinus Trouble
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumors/Growths
- ☐ Ulcers
- ☐ Upset Stomach
- ☐ Whooping Cough
- ☐ Other ____________

Female

Date of last menstrual period ____________ Could you be pregnant? ☐ Yes ☐ No

Work Activity

- ☐ Sitting
- ☐ Standing
- ☐ Light Labor
- ☐ Heavy Labor

Exercise

- ☐ None
- ☐ Moderate
- ☐ Daily
- ☐ Heavy

Habits

- ☐ Smoking — Packs Per Day ____________
- ☐ Alcohol — Drinks Per Week ____________
- ☐ Coffee/Caffeine — Cups Per Week ____________
- ☐ High Stress Level — Reason ____________

Medications ______________________

Vitamins/Herbs/Minerals ______________________

Allergies ______________________

Are you allergic to any lotions? ______________________

Any skin problems? ______________________

It is also my responsibility to keep doctors informed of any changes in my health, and any medications that I may begin to take in the future. I also understand that I am responsible for complying with all exercise, stretches, and treatment as prescribed by the chiropractor. I give my consent to receive the treatment discussed in this and all future appointments and agree that my presence at subsequent appointments shall be construed to be validation of this written consent.

Patient Signature ____ *Date* ____________________