

Medical History Information

Last Name:		Middle:		<input type="checkbox"/> Mr.	<input type="checkbox"/> Miss	Marital status (circle one) Single / Mar / Div / Sep / Widow	
First Name:				<input type="checkbox"/> Mrs.	<input type="checkbox"/> Ms.		
Email:			Birth date:		Age:	Sex:	
Address:			City:		State:		
ZIP Code:		Cell Phone:		Home Phone:			
Occupation:		Employer:			Employer phone:		
Medical Care Information							
Do You Have a Family Doctor?: <input type="checkbox"/> No <input type="checkbox"/> Yes, Name of Doctor: _____							
Have you seen a Chiropractor before?				If yes, then when?			
Medications: _____							
In case of emergency							
Name of Contact:				Relation?			
Contact number:				Allergies:			
Have you had any surgeries? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Last Surgery Date: _____							
Please list surgeries: _____							
Present illness /Conditions: Height _____ Weight _____ Last Blood Pressure (if known) _____/_____							
<input type="checkbox"/> AIDS	<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart Problem	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Spinal Disc Disease			
<input type="checkbox"/> Allergies	<input type="checkbox"/> Cirrhosis/hepatitis	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Thyroid trouble	<input type="checkbox"/> Epilepsy		
<input type="checkbox"/> Anemia	<input type="checkbox"/> Diabetes	<input type="checkbox"/> HIV/ARC	<input type="checkbox"/> Prostate trouble	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/>		
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Dislocated joints	<input type="checkbox"/> Kidney trouble	<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Ulcer	<input type="checkbox"/>		
<input type="checkbox"/> Asthma	<input type="checkbox"/> Diverticulitis	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Scoliosis	<input type="checkbox"/> Polio	<input type="checkbox"/>		
<input type="checkbox"/> Bone fracture	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Mental/ Emotional Difficulty	<input type="checkbox"/> Sinus trouble	<input type="checkbox"/> STD'S	<input type="checkbox"/>		
Other: _____							
Family History of illness:							
<input type="checkbox"/> AIDS	<input type="checkbox"/> Cancer	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Spinal Disc Disease	<input type="checkbox"/> STD'S			
<input type="checkbox"/> Allergies	<input type="checkbox"/> Bone fracture	<input type="checkbox"/> Heart Problem	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Sinus trouble	<input type="checkbox"/> Ulcer		
<input type="checkbox"/> Anemia	<input type="checkbox"/> Cirrhosis/hepatitis	<input type="checkbox"/> HIV/ARC	<input type="checkbox"/> Mental/ Emotional Difficulty	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Polio		
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Diabetes	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Prostate trouble	<input type="checkbox"/> Thyroid trouble	<input type="checkbox"/> Scoliosis		
<input type="checkbox"/> Asthma	<input type="checkbox"/> Dislocated joints	<input type="checkbox"/> Kidney trouble	<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Diverticulitis		
Other: _____							
Type of Cancer: <input type="checkbox"/> Breast <input type="checkbox"/> Lung <input type="checkbox"/> Other: _____							
Social History:							
Alcohol? <input type="checkbox"/> No <input type="checkbox"/> Yes Drinks per week?		Cigarettes? <input type="checkbox"/> No <input type="checkbox"/> Yes Packs per day?		Caffeine? <input type="checkbox"/> No <input type="checkbox"/> Yes Drinks per day?		Exercise? <input type="checkbox"/> No <input type="checkbox"/> Yes (circle one) Light / Moderate / Strenuous	
Misc.: _____							

Signature: _____

Date: _____

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