

Past Health Events	Previous Surgeries (circle one): Ear/nose/throat/ Abdominal/ Other			
	Previous Fractures Or Broken Bones?	Yes	No	Explain: _____
	Previous Falls Or Accidents?	Yes	No	Explain: _____
	Previous Hospitalizations?	Yes	No	Explain: _____
	Previous Car Accidents?	Yes	No	Explain: _____
	Previous Chiropractic Care?	Yes	No	Explain: _____
	Do You Workout or Exercise?	Yes	No	Explain: _____
	Do You Take Any Medications?	Yes	No	List: _____
	Do You Take Any Vitamins/Herbs?	Yes	No	List: _____
Have You Ever Had X-Rays Taken?	Yes	No	Where: _____	
Date of Last Physical Exam: _____		Are You Pregnant?	Yes	No

Check All That Apply	Health Issues:				
	_____ Polio	_____ Arthritis	_____ Diabetes	_____ Sleeplessness	
	_____ Cancer	_____ AIDS or ARC	_____ Heart	_____ Chronic Fatigue	
	_____ Frequent Illness	_____ Allergies	_____ High Stress	_____ Poor Diet	
	_____ Genetic Disorders	_____ Epilepsy	_____ Over Weight	_____ Under Weight	
	Other: _____				
	Habits:	None	Light	Moderate	Heavy
	Alcohol	_____	_____	_____	_____
	Drugs	_____	_____	_____	_____
	Pain Relievers	_____	_____	_____	_____
Caffeine	_____	_____	_____	_____	
Sleep	_____	_____	_____	_____	
Artificial Sweeteners	_____	_____	_____	_____	
Exercise	_____	_____	_____	_____	

Check Any Problem You Have Ever Suffered From	<input type="checkbox"/> Low Back Pain	<input type="checkbox"/> Middle Back Pain	<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Shoulder/Arm Pain
	<input type="checkbox"/> Joint Pain/Stiffness	<input type="checkbox"/> Hip/Leg Pain	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Lungs/Breathing
	<input type="checkbox"/> Blood Pressure	<input type="checkbox"/> Heart Rate	<input type="checkbox"/> Sinus Pain	<input type="checkbox"/> Sinus Infections
	<input type="checkbox"/> Eyes/Vision	<input type="checkbox"/> Throat/Voice	<input type="checkbox"/> Hearing	<input type="checkbox"/> Ear Infection
	<input type="checkbox"/> Dental/TMJ	<input type="checkbox"/> Headaches	<input type="checkbox"/> Nervousness	<input type="checkbox"/> Numbness/Tingling
	<input type="checkbox"/> Muscle Weakness	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Forgetfulness	<input type="checkbox"/> Depression
	<input type="checkbox"/> Fainting	<input type="checkbox"/> Cold Hands/Feet	<input type="checkbox"/> Seizures	<input type="checkbox"/> Stress Reactions
	<input type="checkbox"/> Shaking/Tremors	<input type="checkbox"/> Poor Appetite	<input type="checkbox"/> Nausea	<input type="checkbox"/> Excessive Thirst
	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Constipation	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Weight Loss/Gain
	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Change in Stools	<input type="checkbox"/> Genital Issues	<input type="checkbox"/> Pain With Urination
	<input type="checkbox"/> Frequent Urination	<input type="checkbox"/> Infrequent Urination	<input type="checkbox"/> Weak Stream	<input type="checkbox"/> Bladder Control
	<input type="checkbox"/> Menstrual	<input type="checkbox"/> Fertility Issues	<input type="checkbox"/> Lumps (Breast/Genital)	

Notes (for doctor's use only)	_____

Medications	Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)	

Medication Allergies	Medication	Reaction	Date of onset	Additional Comments	

Nutritional Supplements	<input type="checkbox"/>	I am interested in speaking to the doctor about nutritional supplements
	<input type="checkbox"/>	I would like to explore alternatives to my current medications

All Information on This Form is Confidential

I certify that I have completed this form to the best of my ability, and the statements I have provided are true.

Patient/Guardian Signature: _____ Date: _____