PERSONAL HISTORY

Case Number __________ Date________________

Name ____________________________________ Social Security Number_____________________
Address____
City ____________________________ State _________________________Zip________________
Home Phone ( ) ________________________ Business Phone ( ) ______________________
Date of Birth _________ Age_______ Sex M_____ F _____ Height ___Weight ____ No of Children ___
Single ____ Married ____ Separated ____ Widowed _______ Divorced _______
Business/Employer _______________________ Type of Work ________________________
Spouses' Name ______________________ Spouses' Social Security Number __________________
Referred To This Office By _______________________________________
Who Is Responsible For Your Bill? You___ Spouse ___ Workmans Comp ____ Medicare ____
Auto Insurance ___ Personal Health insurance ____ Other ________________________

CURRENT HEALTH CONDITION

Purpose Of This Appointment ____
Major Complaint ____
Other Doctor(s) Seen For This Condition ____
When Did This Condition Begin ____
Are Others In Your Family With This Same Condition? Yes_____ No_____ If Yes, who? _____________
Is This Condition Job Related _____ OR Work Related ____ Date Of Injury ____________________
If Disabled From Work, Give Dates ____
Medication You Now Take
Nerve Pills_______ Pain Killers/ Muscle Relaxers ______ Blood Pressure _____ Insulin ____
Aspirin _________ Other ____

PAST HEALTH CONDITIONS

Major Surgeries/ Operations: Appendix ______ Tonsils____ Gallbladder ____Hernia _____Heart ____
Back ______Neck _____ Leg _____ Other __________________________________
Major Accidents Or Falls____
Hospitalization (Other Than Above) ____
Have You Had Previous Chiropractic Care? Yes ______ No _____
If Yes, Doctors Name and Approx. Date Of Last Visit ____
Have You Been Treated For Any Health Condition In The Past Year? Yes _____ No _____
If Yes, Please Explain ____
Does Anyone In Your House Have The Same Or Similar Condition? Yes ______ No ______
If Back ______Neck _____ Leg _____ Other __________________________________
Major Accidents Or Falls____
Hospitalization (Other Than Above) ____
Have You Been Treated For Any Health Condition In The Past Year? Yes _____ No _____
If Yes, Please Explain ____
Does Anyone In Your House Have The Same Or Similar Condition? Yes ______ No ______
If Yes, Who? ____

Below are a list of diseases which may seem unrelated to the purpose of your appointment, however these questions must be answered carefully as these problems can affect your overall course of chiropractic care.

Mark any of the following diseases you have had

			Daily Intake
__ Anemia	__ Heart Disease	__ Pneumonia	___ Alcohol
__ Arthritis	__ Influenza	__ Polio	___ Cigarettes___ packs per day
__ Cancer	__ Lumbago	__ Rheumatic Fever	___ Coffee ___cups per day
__ Chicken Pox	__ Measles	__ Small Pox	___ Tea ____ cups per day
__ Diabetes	__ Mental Disorder	__ Thyroid	___ White Sugar
__ Eczema	__ Mumps	__ Tuberculosis	
__ Epilepsy	__ Pleurisy	__ Whooping Cough	

Mark any of the following you have had in the past 6 months

___ Arm Pain	___Liver Problems	___ Bladder Trouble
___ Difficult Chewing/ Jaw Clicking	___ Poor/ Excessive Appetite	___ Discolored Urine
___ General Stiffness	___ Vomiting	___ Painful Urination
___Joint Pain/ Stiffness	___ Weight Trouble	
___ Low back Pain		
___ Neck Pain		
___ Pain Between Shoulders		
___ Walking Problems		

___ Cold/Tingling Extremities	___ Ankle Swelling	___ Allergies
___ Confusion/ Depression	___ Blood Pressure Problems	___ Dental Problems
___ Convulsions	___ Chest Pain	___ Fatigue
___ Dizziness	___ Heart Problems	___ Earache
___ Fainting	___ Irregular Heartbeat	___ Fever
___ Forgetfulness	___ Lung Problems/ Congestion	___ Hearing Difficulty
___ Nervous	___ Short Breath	___ Headaches
___ Numbness	___ Stroke	___ Sore Throat
___ Paralysis	___ Varicose Veins	___ Loss Of Sleep
___ Stress		___ Stuffed Nose
___ Abdominal Cramps	___ Breast Pain/ Lumps	
___ Black/ Bloody Stool	___ Menstrual Cramping	Females Only
___ Colitis	___ Menstrual irregularity	Are you Pregnant? _______________
___ Constipation	___ Prostate/ Sexual Dysfunction	Date of Last Period ______________
___ Diarrhea	___ Vaginal Pain/ Infections	
___ Frequent Nausea	___ Gall Bladder Problems	
___ Gas/Bloating After Meals		
___ Heartburn		
___ Hemorrhoids