MEDICAL HISTORY

PLEASE FILL IN THE APPROPRIATE SPACES (All information is confidential):

CHIROPRACTIC HISTORY

When did you last see a chiropractor? _____ Dr. _____

Why did you see him/her? _____ Were you helped? ☐ Yes ☐ No

Why are you changing chiropractors?_____

Are you currently wearing? o Heel Lifts o Arch Supports

SURGICAL HISTORY

What surgeries have you had & when?

(i.e. gall bladder 2-28-2000)

_____ _____

_____ _____

_____ _____

_____ _____

PRESCRIPTION DRUGS

List supplements & drugs (both non-prescription & prescription), & the reason you are taking them.

(i.e. ibuprofen inflammation / pain)

_____ _____

_____ _____

_____ _____

_____ _____

FAMILY HISTORY (*Excluding yourself*)

Check any and all conditions in your family history.

❑ Cancer ❑ Strokes/TIA's
❑ Headaches ❑ Heart disease
❑ Adopted/Unknown ❑ Diabetes
❑ Cardiac disease (below age 40)
❑ Neurological disease
❑ Psychiatric disease
❑ Inflammatory arthritis
❑ Other _____
❑ None of the above

Deaths in immediate family:

Relationship/Cause Age at Death

_____

_____

_____

_____

ALLERGIES

What allergies & reactions do you have (both medical & environmental)? What was onset date?

(i.e. pollen sneezing & itchy eyes 4-1-98)

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

SOCIAL HISTORY

Smoking ☐ Yes ☐ No
_____ packs / day

Alcohol ☐ Yes ☐ No
_____ drinks / day
_____ socially only

Recreational drugs ☐ Yes ☐ No