

Medical History

Have you ever been to a Chiropractor? Yes No

If yes who & when? _____

Do You Have A Family physician? Yes No

Date of Last Physical Exam: _____

Physician's Name: _____

Address: _____ Phone: _____

Have You Been Hospitalized in the Past? Y N

Date & Reason For Hospitalization: _____

Have you Ever had Surgery? Yes No

Date, Reason, Results of Surgery: _____

Have You Ever Had A Serious Accident/Injury? Y N

List Date & Describe Injury:

Auto: _____

Work-Related: _____

Personal: _____

Sports Injury: _____

Other: _____

Are You Currently Taking Any Vitamins, Minerals, or Herbs? Yes No

Are You Currently Taking Any Medications? Y N

For What Condition(s) Are You Taking medication?

Anti-Inflammatory: (Aspirin, Ibuprofen, Motrin, etc.) _____

Pain/Analgesics: _____

Anti-Depressants: _____

Muscle relaxants: _____

Blood Pressure Pills: _____

Antibiotics: _____

Other: _____

In the past have you use any of the Following?

Birth control Pills

Corticosteroid

Are You Allergic To Any Medications? Yes No

List Medications: _____

What Are Your Current Habits?

Smoking/packs per day? Never <1 1-2 2-3 3-4 5+

Glasses per Day

Caffeinated beverages per day? Never <1 1-2 2-3 3-4 5+

Alcohol Intake? Never <1 1-2 2-3 3-4 5+

Days per Week

Exercise Never <1 1-2 2-3 3-4 5+

Kinds of Exercise You Do:

Walking Jogging Cycling Swimming Golf

Tennis Strength Training Other _____

Drug/Substance Abuse? Yes No

WOMEN ONLY:

To Your Knowledge, **Are You Pregnant** Y N

If pregnant in Past, Were Pregnancies Normal? Y N

Are You Seeing An OB-GYN Regularly? Y N

Number of Births: ___ Date of Last Exam: ___

Physician's Name: _____

Address: _____

Phone: (____) _____

Family History

	Cancer	Diabetes	Heart Trouble	High BP	Stroke	Kidney Disease	Anemia	Mental Illness	Headaches	Osteoporosis	Arthritis	Joint Problem	Scoliosis	Back Problems	Disc Problem	Congenital Defects	Genetic Disease	Other	Decease
Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brothers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sisters	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other:___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

OCCUPATIONAL INFORMATION – ACTIVITIES OF DAILY LIVING

Are You Right or Left Hand? Right Left

Job Type

Retired Unemployed Full-Time Student

If any Of Above Check, Skip Rest and Sign at patient's Signature

Full Time Part Time Temporary Self-Employed

During Your Work Week, You Work how Many? Hr ___ Day ___

How Long Have You Been With Your Present employer? _____

What is Your Primary Work Position and Location?

Work Position: Seated Standing Other _____

Work Location: Desk Counter Workbench Other _____

What Movement Does Your Job Require?

Bending Turning Stooping Twisting Walking

Repetitive Hand Use Carrying Other _____

Does Your Work Include any of the Following Use?

Prolonged Computer Continuous Phone

Does Your Job Involve Lifting?

Never Occasionally Intermittently Frequently

Constant Other _____

How many Pounds? 10lbs 20lbs 30lbs 40lbs 50lbs

Patient's Signature: _____ Date: _____