

Name: _____		Date of Birth: / /	Age: _____
Address: _____		Marital Status: _____	
City: _____	State: _____	Height: ' "	Gender: <input type="checkbox"/> Male
Cell Phone: _____		Weight: lbs	<input type="checkbox"/> Female
Home Phone: _____		Referred by: _____	
May we contact you by...		<input type="checkbox"/> Phone?	<input type="checkbox"/> Email?
		<input type="checkbox"/> Voicemail?	

HEALTH HISTORY
Please describe the reason for your visit: _____
How long have you had this condition? _____
Previous treatments for this condition: _____
<input type="checkbox"/> Chiropractic <input type="checkbox"/> Acupuncture <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Massage Therapy <input type="checkbox"/> Injection:

PERSONAL MEDICAL HISTORY
General symptoms:
<input type="checkbox"/> Cancer <input type="checkbox"/> Anemia <input type="checkbox"/> Dermatitis <input type="checkbox"/> Drug/alcohol abuse <input type="checkbox"/> Fatigue Type(s): _____ Date Diagnosed: / / <input type="checkbox"/> Herpes/Shingles <input type="checkbox"/> History of fever/chills <input type="checkbox"/> IV drug use <input type="checkbox"/> Psoriasis/skin condition <input type="checkbox"/> Prolonged steroid use <input type="checkbox"/> Sleeping difficulties <input type="checkbox"/> SLE (Lupus)
Cardiovascular:
<input type="checkbox"/> Arteriosclerosis <input type="checkbox"/> Bleeding disorders <input type="checkbox"/> Blood clots <input type="checkbox"/> Chest pain <input type="checkbox"/> Congestive heart failure <input type="checkbox"/> Deep vein thrombosis <input type="checkbox"/> Heart attacks <input type="checkbox"/> Heart disease <input type="checkbox"/> High blood pressure <input type="checkbox"/> Pacemaker <input type="checkbox"/> Palpitations <input type="checkbox"/> Pulmonary embolism
Endocrine:
<input type="checkbox"/> Adrenal disease <input type="checkbox"/> Diabetes <input type="checkbox"/> Goiter <input type="checkbox"/> Low thyroid <input type="checkbox"/> Parathyroid disease <input type="checkbox"/> Pituitary disease
Gastrointestinal:
<input type="checkbox"/> Constipation <input type="checkbox"/> Digestive problems <input type="checkbox"/> Gall bladder problems <input type="checkbox"/> GERD <input type="checkbox"/> Heart burn <input type="checkbox"/> Hepatitis <input type="checkbox"/> High cholesterol <input type="checkbox"/> Liver disease <input type="checkbox"/> Nausea <input type="checkbox"/> Ulcer/GI bleeding
Genito-Urinary:
<input type="checkbox"/> Inability to control bladder <input type="checkbox"/> Increased urinary frequency <input type="checkbox"/> Loss of sexual function <input type="checkbox"/> Painful urination <input type="checkbox"/> Kidney stones <input type="checkbox"/> Prostate problems <input type="checkbox"/> Urinary retention
Gynecology:
<input type="checkbox"/> Hot Flashes <input type="checkbox"/> Menstrual cramps <input type="checkbox"/> Miscarriage <input type="checkbox"/> Pregnancy <input type="checkbox"/> PMS Date of last menstrual cycle: / /
Eyes, Ears, Nose & Throat:
<input type="checkbox"/> Blindness <input type="checkbox"/> Blurred vision <input type="checkbox"/> Cataracts <input type="checkbox"/> Deafness/reduced hearing <input type="checkbox"/> Glaucoma <input type="checkbox"/> Ringing/buzzing in ears <input type="checkbox"/> Sinus problems
Musculoskeletal:
<input type="checkbox"/> Arthritis <input type="checkbox"/> Back pain <input type="checkbox"/> Conditions aggravated by coughing, sneezing, or grunting <input type="checkbox"/> Constant pain unrelated to movement <input type="checkbox"/> Connective tissue disease <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Fractures <input type="checkbox"/> Gout <input type="checkbox"/> Herniated disc <input type="checkbox"/> History of weakness <input type="checkbox"/> Jaw problems <input type="checkbox"/> Joint swelling <input type="checkbox"/> Night pain unrelated to movement <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Pinched nerve <input type="checkbox"/> Rheumatoid arthritis <input type="checkbox"/> Sciatica <input type="checkbox"/> Scoliosis <input type="checkbox"/> Sjogren's syndrome <input type="checkbox"/> Tendinitis <input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Whiplash injury
Neuropsychological/Balance:
<input type="checkbox"/> Burning, tingling, or numbness into the hips, legs, or feet <input type="checkbox"/> Burning, tingling, or numbness into the shoulders, arms, or hands <input type="checkbox"/> Bi-polar disorder <input type="checkbox"/> Depression <input type="checkbox"/> Dizziness <input type="checkbox"/> Epilepsy/Seizure <input type="checkbox"/> Headaches <input type="checkbox"/> Migraines <input type="checkbox"/> Multiple sclerosis <input type="checkbox"/> Nervousness/Anxiety <input type="checkbox"/> Parkinson's disease <input type="checkbox"/> Poor balance <input type="checkbox"/> Stroke <input type="checkbox"/> Schizophrenia
Respiratory:
<input type="checkbox"/> Asthma <input type="checkbox"/> Bronchitis <input type="checkbox"/> Emphysema <input type="checkbox"/> Pneumonia <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Sleep apnea

FAMILY MEDICAL HISTORY

Problems that run in your family:

- Asthma Cancer Diabetes Heart disease
- High blood pressure Seizures Stroke Spine disease

PERSONAL MEDICAL HISTORY CONTINUED

Surgeries:

Year	Surgery

Prescribed medications, over-the-counter medications, herbs, vitamins and inhalers:

Product	Reason	Dosage

Allergies:

HEALTH HABITS

Exercise:

How often do you exercise?

- Never Rarely Occasionally Weekly Daily

Type: _____

If you exercise, what is the intensity?

- Light Moderate Strenuous

Habits:

Do you drink alcohol?

- Never Once a week Several times a week Once daily Several times per day

Tobacco use:

- Cigarettes:**
- Never Used in the past Less than ½ pack per day ½ pack per day
 - 1 pack per day 2 packs per day More than 2 packs per day
- Chewing tobacco:**
- Never Used in the past Occasionally Often
- Cigars:**
- Never Used in the past Occasionally Often

For how many years have you used tobacco products? _____

If you have quit smoking, when did you quit? _____