PAST HISTORY

Your Personal Primary Care Giver / Physician __________________ Clinic__________________________

Have you had similar pain in the past? YES NO **Explain____**

Have you been in any car accidents? YES NO **When?__________Injuries?__________________________**

Have you had any bad falls? YES NO **If yes, Explain? ____**

List any injuries from falls, accidents, head injuries, broken bones or dislocations? If you have had any, please state what part of your body the injury happened and when it happened (specify left or right side):

____

HEALTH HISTORY – CIRCLE ANY OF THE FOLLOWING THAT YOU HAVE HAD:

*AIDS/HIV *Alcoholism*Allergy Shots*Anemia*Anorexia*Appendicitis*Arthritis*Asthma*Bleeding Disorder *Breast Lump*Bronchitis* Cataracts* Cancer* Chemical Dependency*Chicken Pox* Diabetes* Depression* Emphysema * Epilepsy* Glaucoma* Goiter* Gout* Gonorrhea* Heart Disease* Hepatitis* Hernia* Herniated Disc* High Cholesterol* High Blood Pressure*Multiple Sclerosis* Pacemaker* Parkinson's Disease* Pinched Nerve* Pneumonia*Polio*Prostrate Problems*Prosthesis*Psychiatric Care*Rheumatoid Arthritis*Scarlet Fever*Scoliosis* Stroke*Suicide Attempt*Thyroid Problems*Tonsillitis*Tuberculosis*Tumors or Growths*Typhoid Fever* Ulcers*Venereal Disease*Whooping Cough*Other______________________________

Have you had Cancer? YES NO **If so, what kind and when?_______________________________________**

List any illnesses that run in your family: ____

List any medications that you take and what you take them for: _____________________________________

____

List any surgeries that you have had and when you had them:____

____

Are you pregnant or do you think you may be? YES NO **Date of last period?_________________________**

HABITS

Tobacco User Y/N	Chew, Cigar, Cigarettes
Former User Y/N	How much/Day_______
Alcohol	Drinks/Week_________
Coffee	Cups/Day___________
Soda	Cans/Day___________
High Stress Level	Reason______________

EXERCISE: Yes or No If yes, What?___________________
How many times per week?_____________

Have you had previous Chiropractic Care? Yes or No
If yes, when was your last treatment?_____________

AGE______ HEIGHT____'____" WEIGHT_______Lbs.

Signature____ Date_____/_____/_______