NAME_____DATE_____

HEALTH HISTORY

HAVE YOU EVER HAD ANY MAJOR SURGERY/ OPERATIONS? YES NO

PLEASE LIST TYPE OF SURGERY AND DATE:_____

HOSPITALIZATIONS OTHER THAN ABOVE?_____

HAVE YOU BEEN TREATED FOR ANY HEALTH CONDITION IN THE PAST YEAR?_____

ARE YOU CURRENTLY UNDER A PHYSICIAN'S CARE FOR ANY ONGOING HEALTH PROBLEMS?_____

PHYSICIAN'S NAME AND PHONE#_____

HAVE YOU HAD ANY MAJOR FALLS OR ACCIDENTS? YES NO IF YES, PLEASE EXPLAIN_____

ARE YOU CURRENTLY TAKING ANY PRESCRIPTION MEDICATION? PLEASE LIST TYPE, AMOUNT AND FREQUENCY_____

ARE YOU CURRENTLY TAKING ANY OVER-THE-COUNTER MEDICATIONS, VITAMINS, HERS? PLEASE LIST TYPE, AMOUNT, AND FREQUENCY_____

PREVIOUS CHIROPRACTIC CARE: DOCTOR'S NAME AND APPROPRIATE DATE OF LAST VISIT:_____

HAVE YOU OR ANY MEMBER OF YOUR FAMILY HAD ANY OF THE FOLLOWING? PLEASE CHECK ALL THAT APPLY

___HEART CONDITION	___DIABETES	___HIGH BLOOD PRESSURE
___LIVER DISORDERS	___KIDNEY DISORDERS	___EPILEPSY
___NERVOUS DISORDERS	___CIRCULATORY DISORDERS	___SKIN DISORDERS
___INDIGESTION	___ALLERGIES	___ASTHMA
___LUNG DISORDERS	___STROKE	___ANXIETY
___EAR INFECTIONS	___SINUS PROBLEMS	___INTESTINAL DISORDERS
___HEADACHES	___BACK PAIN	___PMS

PLEASE TELL US HOW YOU HEARD ABOUT US. DID SOMEONE REFER YOU HERE?_____