Medical History Information

Last name:	Middle:	First:	Nickname:

Spouse's Name:
Do you have children? ❑ Yes ❑ No Ages: _____ _____ _____ _____ _____
Email:

Address:	City:	State:	Zip:
Home Phone:	Work Phone:	Cell Phone:	
Sex : Male / Female	Date of Birth:	Age:	

Employment (circle one)
Employed Homemaker Student P/T F/T
Child Retired Disabled

Occupation:

Employer:

Marital status (circle one)
Single / Mar / Div / Sep / Widowed

Referred by:

Other family members seen here:

Medical Care Information

Do You Have a Family Doctor/Primary Care Physician?: ☐ Yes ☐ No
If Yes, would you like to have a copy of your report for this visit send to your PCP? ☐ Yes ☐ No

Name of Family Doctor:

Street:	City:	State:	ZIP Code:

Date of last Visit: / / /
Date of last **e**xam: / / /

Have you Had Surgeries in the last 5 Years: ☐ Yes ☐ No

Reason for Surgery:

Current Condition

The reason for this visit:

When did this condition begin?	Is this condition getting worse?	The pain/discomfort…
/ /	❑ Yes ❑ No	❑ is constant ❑ comes & goes

Have you been treated by a Medical Physician for this condition? ❑ Yes ❑ No
If so, who, when & where? Phone#

Have you ever been treated by a Chiropractor before? ❑ Yes ❑ No Was it for the current condition? ❑ Yes ❑ No
If so, who, when & where? Phone#

Present Illness /Conditions:

☐ AIDS	☐ Cancer	☐ Heart Problem	☐ Multiple Sclerosis	☐ Spinal Disc Disease	
☐ Allergies	☐ Cirrhosis/hepatitis	☐ High blood pressure	☐ Pacemaker	☐ Thyroid trouble	☐ Epilepsy
☐ Anemia	☐ Diabetes	☐ HIV/ARC	☐ Prostate trouble	☐ Tuberculosis	☐
☐ Arthritis	☐ Dislocated joints	☐ Kidney trouble	☐ Rheumatic fever	☐ Ulcer	☐
☐ Asthma	☐ Diverticulitis	☐ Low Blood Pressure	☐ Scoliosis	☐ Polio	☐
☐ Bone fracture	☐ Hay Fever	☐ Mental/ Emotional Difficulty	☐ Sinus trouble	☐ STD'S	☐

Other:

Family History of illness:

☐ AIDS	☐ Cancer	☐ Multiple Sclerosis	☐ Spinal Disc Disease	☐ STD'S	
☐ Allergies	☐ Bone fracture	☐ Heart Problem	☐ Low Blood Pressure	☐ Sinus trouble	☐ Ulcer
☐ Anemia	☐ Cirrhosis/hepatitis	☐ HIV/ARC	☐ Mental/ Emotional Difficulty	☐ Epilepsy	☐ Polio
☐ Arthritis	☐ Diabetes	☐ High blood pressure	☐ Prostate trouble	☐ Thyroid trouble	☐ Scoliosis
☐ Asthma	☐ Dislocated joints	☐ Kidney trouble	☐ Rheumatic fever	☐ Tuberculosis	☐ Diverticulitus

Other:

Type of Cancer: ☐ Breast ☐ Lung ☐ Other:

Alcohol Consumer? ❑ Yes ❑ No _____drinks/week	Tobacco Use ❑ Yes ❑ No _____packs/day	Caffeine Use ❑ Yes ❑ No _____ drinks/day
Exercise? ❑ Yes ❑ No _____ hours/week	Special Diet? ❑ Yes ❑ No Since: _______ Supplement with vitamins? ❑ Yes ❑ No	Do you wear orthotics? ❑ Yes ❑ No Age of mattress:

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Patient Signature: ____ Date:_________________

Office use only: Entered by: _____ **DC reviewed:** _____ **OM Reviewed:** _____ **Scanned: By:** _______