Health History

Patient Name: _____ Date: _____

Please mark treatment(s) you have already received for your condition?

( ) None ( ) Medications ( ) Surgery ( ) Physical Therapy ( ) Chiropractic Services ( ) Other_____

Please provide the name, address and phone number of the doctor(s) who have treated you for your condition:

_____

_____

Date of Last: Physical Exam_____ Spinal X-Ray_____ Blood Test_____

Spinal Exam_____ Urine Test_____ MRI, CT-Scan, Bone Scan_____

Place a mark on "Yes" or "No" to indicate if you have had or have ever been* TREATED *for any of the following:

AIDS/HIV	( ) Yes ( )No	Diabetes	( )Yes ( )No	Migraines	( )Yes ( )No	Rheumatic Fever	( )Yes ( )No
Alcoholism	( )Yes ( )No	Emphysema	( )Yes ( )No	Miscarriage	( )Yes ( )No	Scarlet Fever	( )Yes ( ) No
Allergy Shots	( )Yes ( )No	Epilepsy	( )Yes ( )No	Mononucleosis	( )Yes ( )No	Stroke	( )Yes ( ) No
Anemia	( )Yes ( )No	Fracture	( )Yes ( )No	Measles	( )Yes ( )No	Suicide Attempt	( )Yes ( ) No
Anorexia	( )Yes ( )No	Glaucoma	( )Yes ( )No	Multiple Sclerosis s	( )Yes ( )No	Thyroid Problems	( )Yes ( ) No
Appendicitis	( )Y es ( )No	Goiter	( )Yes ( )No	Mumps	( )Yes ( )No	Tonsillitis	( )Yes ( ) No
Arthritis	( )Yes ( )No	Gonorrhea	( )Yes ( )No	Osteoporosis	( )Yes ( )No	Tuberculosis	( )Yes ( ) No
Asthma	( )Yes ( )No	Gout	( )Yes ( )No	Pacemaker	( )Yes ( )No	Tumors/Growths	( )Yes ( ) No
Bleeding Disorders	( )Yes ( )No	Heart Disease	( )Yes ( )No	Parkinson's Dz.	( )Yes ( )No	Ulcers	( ) Yes( ) No
Breast Lump	( )Y es ( ) No	Hepatitis	( )Yes ( )No	Pinched Nerve	( )Yes ( )No	Vaginal Infections	( )Yes ( ) No
Bronchitis	( )Yes ( )No	Hernia	( )Yes ( )No	Pneumonia	( )Yes ( )No	Venereal Dz.	( ) Yes ( ) No
Bulimia	( )Yes ( )No	Herniated Disc	( )Yes ( )No	Polio	( )Yes ( )No	Other_____	
Cancer	( )Yes ( )No	Herpes	( )Yes ( )N o	Prostate Problems	( )Yes ( )No	_____	
Cataracts	( )Yes ( )No	High Cholest.	( )Yes ( )No	Prosthesis	( )Yes ( )No	_____	
Chemical Dependency	( )Yes ( )No	Kidney Dz.	( )Yes ( )No	Psychiatric Care	( )Yes ( )No	_____	
		Liver Disease	( )Yes ( )No	Rheumatoid Arth.	( )Yes ( )No	_____	
Chicken Pox	( )Yes ( )No						

Please list any medications you are currently taking: include additional health information that you feel is important.

_____

_____

_____

DO ANY OF THESE CONDITIONS PERTAIN TO YOU?

_____Pregnant _____Active Cancer _____Metal Implants (I.U.D, staples, hips, etc.)

_____Pacemaker _____Serious Heart Conditions _____Blood Thinners

WARNING AND CONSENT TO X-RAY

I understand that if I am pregnant and have x-rays taken, which expose my lower torso to radiation, it is possible to injure the fetus. I have been advised that the 10 days following onset of a menstrual period are generally considered to be safe for x-ray exams.

An x-ray may be performed on me with my consent.

Signature_____ Date_____