

HEALTH HISTORY

What treatment have you already received for your condition? Medication Surgery Physical Therapy Chiropractic

None Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Place a mark if you have had any of the following:

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Measles | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Allergy Shots | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Fractures | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Sexually Transmitted Disease |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Goiter | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Suicide Attempt |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Mumps | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Gout | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Tumors, Growths |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Hernia | <input type="checkbox"/> Pinched Nerve | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Herniated Disk | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Herpes | <input type="checkbox"/> Polio | <input type="checkbox"/> Vaginal Infections |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Prostate Problem | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Prosthesis | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Psychiatric Care | |

Are you pregnant? Yes No Due Date _____

EXERCISE

- None
- Moderate
- Daily
- Heavy

WORK ACTIVITY

- Sitting
- Standing
- Light Labor
- Heavy Labor

HABITS

- Smoking Packs/day _____
- Alcohol Drinks/week _____
- Coffee/Caffeine Cups/day _____
- High Stress Level Reason _____

Current Height _____ Weight _____

Injuries/Surgeries you have had	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

MEDICATIONS

ALLERGIES

VITAMINS/HERBS/MINERALS
