

# post chiropractic Medical History

Date \_\_\_\_\_

Name \_\_\_\_\_ Account Number \_\_\_\_\_

Check all that apply

|                           | Past | Now | Family |
|---------------------------|------|-----|--------|
| Lung disease              |      |     |        |
| Heart disease             |      |     |        |
| Stomach disease           |      |     |        |
| Bladder disease           |      |     |        |
| Liver disease             |      |     |        |
| Kidney disease            |      |     |        |
| Colon disease             |      |     |        |
| Thyroid disease           |      |     |        |
| Circulatory disease       |      |     |        |
| Mental/Emotional disorder |      |     |        |
| High blood pressure       |      |     |        |

|                         | Past | Now | Family |
|-------------------------|------|-----|--------|
| Low blood pressure      |      |     |        |
| Arthritis               |      |     |        |
| Swollen/Painful joints  |      |     |        |
| Recent weight loss/gain |      |     |        |
| Diabetes                |      |     |        |
| Seizures/Epilepsy       |      |     |        |
| Cancer                  |      |     |        |
| HIV/AIDS                |      |     |        |
| Arteriosclerosis        |      |     |        |
| Polio                   |      |     |        |
| Rheumatic Fever         |      |     |        |

Have you had:

|               | 6 mos. | 6-18 m | 18+ m | never |
|---------------|--------|--------|-------|-------|
| Spinal exam   |        |        |       |       |
| Physical exam |        |        |       |       |
| Eye exam      |        |        |       |       |
| Chest X-ray   |        |        |       |       |

|              | 6 mos. | 6-18 m | 18+ m | never |
|--------------|--------|--------|-------|-------|
| Spinal X-ray |        |        |       |       |
| Dental X-ray |        |        |       |       |
| Blood test   |        |        |       |       |
| Urine test   |        |        |       |       |

Frequency

|          | Alcohol | Coffee | Tobacco | Exercise | Sleep | Appetite | Sweets |
|----------|---------|--------|---------|----------|-------|----------|--------|
| Heavy    |         |        |         |          |       |          |        |
| Moderate |         |        |         |          |       |          |        |
| Light    |         |        |         |          |       |          |        |
| None     |         |        |         |          |       |          |        |

List any conditions not found above about yourself or your family: \_\_\_\_\_

List any surgeries and/or accidents and the dates: \_\_\_\_\_

List vitamins, mineral supplements, and current medications and reason taken: \_\_\_\_\_

List any known or suspected allergies: \_\_\_\_\_

Please circle if you are wearing:      heel lifts    sole lifts    inner soles    arch supports    other \_\_\_\_\_

Date of last chiropractic exam: \_\_\_\_\_ by Dr. \_\_\_\_\_

**Emergency contact (relative or close friend not living in your home)**

Name \_\_\_\_\_ Relation \_\_\_\_\_

Phone \_\_\_\_\_ Address \_\_\_\_\_