Date___________

Medical History

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				

	6 mos.	6–18 m	18+ m	never
Spinal X-ray				
MRI or CT				
Blood/Urine test				

Frequency

	Alcohol	Coffee	Tobacco	Exercise	Sleep	Appetite	Other
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____________________________________