Does it hurt to:

Walk	yes	no	Do Housework	yes	no
Sit	yes	no	Drive	yes	no
Stand	yes	no	Exercise	yes	no
Lift	yes	no	Sleep	yes	no
Climb Stairs	yes	no	Take care of dependant's	yes	no
Get in & out of bed	yes	no			

Health History

What treatment have you already received for your condition?

Medications Surgery Physical Therapy Chiropractic None Other____________________

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

____

Date of Last: Physical Exam__________ Spinal X-Ray__________ Blood Test__________

Spinal Exam__________ Chest X-Ray__________ Urine Test__________

Dental X-Ray__________ MRI, CT-Scan, Bone Scan__________________

Are you pregnant? yes no **If yes, what is the Date of your last menstrual period.**______________

Place a mark on "Yes" or "No" to indicate if you have had any of the following.

AIDS/HIV	Yes	No	Emphysema	Yes	No	Migraine Headaches	Yes	No	Sexually Transmitted Disease	Yes	No
Alcoholism	Yes	No	Epilepsy	Yes	No	Miscarriage	Yes	No	Stroke	Yes	No
Allergy Shots	Yes	No	Fractures	Yes	No	Mononucleosis	Yes	No	Suicide Attempt	Yes	No
Anemia	Yes	No	Glaucoma	Yes	No	Multiple Sclerosis	Yes	No	Thyroid Problems	Yes	No
Anorexia	Yes	No	Goiter	Yes	No	Mumps	Yes	No	Tonsillitis	Yes	No
Appendicitis	Yes	No	Gonorrhea	Yes	No	Osteoporosis	Yes	No	Tuberculosis	Yes	No
Arthritis	Yes	No	Gout	Yes	No	Pacemaker	Yes	No	Tumors	Yes	No
Asthma	Yes	No	Heart Disease	Yes	No	Parkinson's Disease	Yes	No	Typhoid Fever	Yes	No
Bleeding Disorders	Yes	No	Hepatitis	Yes	No	Pinched Nerve	Yes	No	Ulcers	Yes	No
Breast Lump	Yes	No	Hernia	Yes	No	Pneumonia	Yes	No	Vaginal Infections	Yes	No
Bronchitis	Yes	No	Herniated Disk	Yes	No	Polio	Yes	No	Whooping Cough	Yes	No
Bulimia	Yes	No	Herpes	Yes	No	Prostate Problem	Yes	No			
Cancer	Yes	No	High Blood Pressure	Yes	No	Prosthesis	Yes	No			
Cataracts	Yes	No	High Cholesterol	Yes	No	Psychiatric Care	Yes	No			
Chemical Dependency	Yes	No	Kidney Disease	Yes	No	Rheumatoid Arthritis	Yes	No			
Chicken Pox	Yes	No	Liver Disease	Yes	No	Rheumatic Fever	Yes	No			
Diabetes	Yes	No	Measles	Yes	No	Scarlet Fever	Yes	No			
			Other	Yes	No______________________						

Exercise	Work Activity
☐ None	☐ Sitting
☐ Moderate	☐ Standing
☐ Daily	☐ Light Labor
☐ Heavy	☐ Heavy Labor

Height______________

Weight______________

B.P.______________

Habits

☐ Alcohol Drinks/Week______________

☐ Coffee/Caffeine Cups/Day______________

☐ High Stress Level Reason______________

☐ Smoking Packs/Day______________

Are you aware of the negative effects of smoking?

☐ yes ☐ no

Are you aware that you can seek medical care to help you stop smoking? ☐ yes ☐ no

Medications	Allergies	Vitamins/Herbs/Minerals

List Surgeries:

*______________________ **Date**__________ *______________________ **Date**__________

*______________________ **Date**__________ *______________________ **Date**__________

Signature:____ **Date**__________