(Staff only) Name:	Account Number:	Date:

Surgery/Hospitalizations

□ I have not had any surgeries or never been in the hospital.
Please list surgeries and the year performed and hospitalizations and the reason.

_____

_____

_____

Past Medical History

(check all that apply)

	Anemia		Blood Clots		Gallbladder		Heart Attack
	Angina		Cancer:		GERD		Osteoarthritis
	Anxiety		Stroke		Hepatitis C		Osteoporosis
	Gout		COPD		High Cholesterol		Fainting
	Asthma		Coronary Disease		High Blood Press.		Rheumatoid Arth.
	Atrial Fibrillation		Crohn's Disease		Irritable Bowel		Dizziness
	Prostate Disease		Depression		Liver Disease		Neck Pain
	Kidney Disease		Diabetes		Migraines		Headaches
	Seizures		Thyroid Disease		Peptic Ulcer		

Review of Systems

(check all that apply)

	Night sweats		Impotence
	Lack of energy		Pain in joints
	Unexplained weight loss or gain		Swelling in joints:
	Facial pain or numbness		Rashes
	Nose bleeds		Skin lesions
	Nasal drip		Hair loss/increase
	Mouth sores		Double vision
	Irregular heart beat		Poor balance
	Chest pains		Visual loss
	Swollen legs or feet		Tremors
	Pain in legs with walking		Headaches
	Shortness of breath		Anxiety
	Prolonged cough		Depression
	Coughing up blood		Intolerance to heat/cold
	Heart burn		Menstrual problems
	Constipation		Easy bruising
	Diarrhea		Frequent thirst
	Incontinence		Easy bleeding
	Painful or frequent urination		Blood diseases
	Prostate problems		Seasonal allergies
	Change in sex drive/energy level		Infections
	Anemia		Other:

(Staff only) Name:	Account Number:	Date:

Family History

Please check and identify the person in your family who has/had the condition

✓		✓	
	Cancer:		Heart Disease:
	Stroke:		Diabetes:
	Cystic fibrosis:		Back problems:
	Rheumatoid Arthritis:		High Blood Pressure:
	Migraines:		Skin lesions:
	Lupus:		Other:

Social History

Number of Children: _____ Alcohol usage: drinks per day? _____ Caffeinated beverages per day _____
Tobacco usage: □ Never or _____packs/day for _____ years. Date quit _____(year)
Advanced Directive: □ Yes □ No □ I do not know Do you use illegal drugs □ No □ Yes
Employer: _____Job title:_____
□ Retired □ Unemployed □ Permanently Disabled If yes when: _____
Level of Education: _____

Medications

□ I have provided an updated list of medications and vitamins to the receptionist (no need to fill out info below).

Please include prescription, over the counter medication and supplements/vitamins/herbs, etc. If you have an update list of medications please provide that to the front desk so a copy can be made.
Here are my medications with doses and date started: (Include amount of pills, strength and times per day you take)
Example: aspirin 80mg 1/day started (Date)

_____/_____
_____/_____
_____/_____
_____/_____

Allergies

□ I have no known allergies to medications, foods or environmental objects.
Please list allergies to medications, environmental allergies and allergies to foods. Please give a brief description of the allergic reaction, when it started (year) and severity.
For example: Penicillin- Feb 2006, Skin rash-mild. Trees-Jan 2004, itchy eyes- moderate

Medication allergies: _____

Environmental allergies: _____

Food allergies: _____

I have read the information provided and answered the questions truthfully to the best of my knowledge, and hereby authorize this office to provide a chiropractic exam and if agreed on care, in accordance with this state's statutes.

Parent or Guardian Signature _____ Date _____