Health History Information

Last Name:		❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms.	Marital status (circle one)
First Name:	Middle:		Single / Married / Partnered Sep / Divorced / Widowed
Spouse/Partner:	Patient's Birth Date:	Age:	Sex:
Children's names/ages: 1.		3.	
2.		4.	
Email:			
Address:	City:	State:	
ZIP Code: SSN:	Home Ph:	Mobile:	
Occupation:	Employer:		

Medical Care Information

Do You Have a Family Doctor? ☐ No ☐ Yes	Name of Doctor:		
Address:	City:	State:	ZIP:
Date of last Visit: / /	Date of last exam: / /		
Do You Have a Family Chiropractor? ☐ No ☐ Yes	Name of Chiropractor:		
Address:	City:	State:	ZIP:
Date of last Visit: / /	Date of last exam: / /		
Have you had surgeries in the last 5 Years: ☐ No ☐ Yes	If yes, Last Surgery Date:		
Reason for Surgery:			

Present illness /Conditions: √ Please check all that apply

☐ AIDS	☐ Cancer	☐ Heart Problems	☐ Multiple Sclerosis	☐ Spinal Disc Disease	
☐ Allergies	☐ Hepatitis	☐ High blood pressure	☐ Pacemaker	☐ Thyroid trouble	☐ Epilepsy
☐ Anemia	☐ Diabetes	☐ Low Blood Pressure	☐ Prostate trouble	☐ Tuberculosis	
☐ Arthritis	☐ Dislocated joints	☐ Kidney trouble	☐ Rheumatic fever	☐ Ulcer	
☐ Asthma	☐ Diverticulitis	☐ HIV +	☐ Scoliosis	☐ Polio	
☐ Bone fracture	☐ Hay Fever	☐ Emotional Difficulty	☐ Sinus trouble	☐ STDs	

Other:

Family History of illness: √ Please check all that apply

☐ AIDS	☐ Cancer	☐ Heart Problems	☐ Multiple Sclerosis	☐ Spinal Disc Disease	
☐ Allergies	☐ Hepatitis	☐ High blood pressure	☐ Pacemaker	☐ Thyroid trouble	☐ Epilepsy
☐ Anemia	☐ Diabetes	☐ Low Blood Pressure	☐ Prostate trouble	☐ Tuberculosis	
☐ Arthritis	☐ Dislocated joints	☐ Kidney trouble	☐ Rheumatic fever	☐ Ulcer	
☐ Asthma	☐ Diverticulitis	☐ HIV +	☐ Scoliosis	☐ Polio	

Other:

Patient's Habits & Lifestyle

Alcohol? ☐ No ☐ Yes # Drinks/week?	Cigarettes? ☐ No ☐ Yes # Packs/day?	Caffeine? ☐ No ☐ Yes # Drinks/day?	Exercise? ☐ No ☐ Yes # Hours/week? (circle one) Light / Moderate / Strenuous

Other:

Signature: _____ Date: _____

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.