HEALTH HISTORY

Name:_____ Home Phone:_____Cell Phone:_____

Address:_____ City/State/Zip:_____

Birth Date:_____ Age:_____ Marital Status: S M W D Children?_____

Occupation:_____Employer:_____ Work Phone:_____

Emergency Contact Name and Phone #:_____

Medical Doctor Name:_____ Last Physical Exam:_____

How did you find out about this office?_____

Describe your main problem and any secondary problems:_____

_____

Does the pain travel to any other area?____ If yes where?_____

Date it started ?_____ What caused it ?_____

Have you had this problem before?_____ When?_____

How bad is the pain? (Circle one) Mild Moderate Severe Intolerable

Is the pain getting (circle one) Better Worse No Change

How often does the pain occur? (Circle one) Occasional Frequent Constant

How long does the pain last when it occurs?_____

What makes the pain worse?_____

What makes the pain better?_____

Have you seen another doctor for this problem? _____ If yes, who did you see and what

was done:_____

_____

List all surgeries and dates:_____

_____

Have you suffered any physical injuries such as falls, auto accidents, whiplash, head injuries,

sprains, broken or cracked bones?_____ If yes describe:_____

_____

List any medications you now take:_____

_____

Are you currently under another doctors care?____ If yes who and for what:_____

_____

Have you had chiropractic care before?____ If yes when and where:_____

Do you exercise regularly?_____ Do you smoke?_____

Women only: Is there a chance you are currently pregnant?_____

Family Health:

Please indicate, by circling, any conditions below that relate to you the patient = P, mother = M father = F, children = C.

P M F C	Scoliosis	P M F C	Back/disc problems	P M F C	Arthritis
P M F C	Headaches	P M F C	High blood pressure	P M F C	Cancer
P M F C	Diabetes	P M F C	Digestive problems	P M F C	Heart problems
P M F C	Other:_____				

Health Insurance Carrier:_____

I certify that the information given is true and accurate to the best of my knowledge

Signature:_____ Date:_____