HEALTH HISTORY

What treatment have you already received for your condition?
□ Medications □ Surgery □ Physical Therapy □ Chiropractic □ None
□ Other_____

Name of the Facility/Doctor where and who treated you_____

Date of Last: (Mark dates that you know)

Physical Exam_____ Spinal X-ray_____
Spinal Exam_____ Chest X-ray_____
Dental X-ray_____ Blood Test_____
Urine Test_____ MRI_____
CT-Scan_____ Bone Scan_____

Place a check mark to indicate that you **have** had any of the following:

AIDS/HIV____	Diabetes____	Migraine Headaches____	Stroke____
Alcoholism____	Bulimia____	Anorexia____	Emphysema____
Epilepsy____	Anemia____	Allergy Shots____	Bleeding Disorders____
Asthma____	Gout____	Goiter____	Multiple Sclerosis____
Measles____	Mumps____	Fractures____	Arthritis____
Osteoporosis____	Polio____	Prosthesis____	Parkinson's Disease____
Hernia____	Cancer____	Bronchitis____	Breast Lump____
Pacemaker____	Pinched Nerve____	Prostate Problem____	Psychiatric Care____
Ulcers____	Hepatitis____	Chicken Pox____	Chemical Dependency____
Cataracts____	Glaucoma____	Heart Disease____	High Cholesterol____
Tuberculosis____	Liver Disease____	Kidney Disease____	Herniated Disk____
Rheumatoid Arthritis____		Thyroid Problems____	Tumors/Growths____
Sexually Transmitted Disease____			

Other_____

Exercise: □ None □ Moderate □ Daily □ Heavy

Work Activity: □ Sitting □ Standing □ Light Labor □ Heavy Labor

Habits:
□ Smoking Packs/Day_____
□ Alcohol Drinks/Week_____
□ Coffee Cups/Day_____
□ High Stress Reason_____

Are you pregnant? □ Yes □ No Due Date_____

Injuries/Surgeries you have had:

Falls_____ Date_____
Head Injuries_____ Date_____
Broken Bones_____ Date_____
Dislocations_____ Date_____
Surgeries_____ Date_____

Please list any medications and the dosage you are presently taking including vitamin/herbal supplements.

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Please list any allergies to medications/supplements you have._____