Personal and Family Health History

Name _____ Referred by _____
Date _____ Social Security #_____
Address _____ Occupation _____
City _____ State ____ Zip _____ Employer _____
Date of Birth _____ Age _____
Phone (Home) _____ (Cell)_____
(Work) _____
Marital Status: S M D W Spouse's Name _____
Email _____ Spouse's Occupation _____

Trauma History

List all traumas related to car accidents, sports, hobbies at work and at home:

_____
_____

Health History

Do you smoke? Yes No If yes, how many packs per day? _____
Do you drink? Yes No
Have you ever had surgery? Yes No Surgery type and date:_____
_____

Please list medications you take (prescription and non-prescription):
_____

Current Health Condition

Present complaint or reason for your visit today: _____
Is this condition getting progressively worse? _____
Have you seen other doctors for this condition? _____
Have you visited a chiropractor before? _____

Is there family history of (Circle all that apply): Heart Disease, Arthritis, Cancer, Diabetes, Other
Give details: _____

Is there a personal history of (Circle all that apply): Heart Disease, Arthritis, Cancer, Diabetes, Other
Give details: _____

Current Symptoms

❑ Neck pain	❑ Dizziness	❑ Chest pain	❑ Lack of sleep
❑ Mid back pain	❑ Loss of memory	❑ Short of breath	❑ Depression
❑ Low back pain	❑ Loss of balance	❑ Fatigue	❑ Nervousness
❑ Headaches	❑ Loss of taste	❑ Fainting	❑ Constipation
❑ Shoulder pain	❑ Loss of smell	❑ Cold sweats	❑ Diarrhea
❑ Numbness (hands)	❑ Ears ringing	❑ Cold hands	❑ Fever
❑ Numbness (feet)	❑ Light sensitivity	❑ Cold feet	❑ Upset stomach

_____ _____
Signature Date