Patient Name_____Date_____

Medical History

Are you currently being treated for any conditions? _____Yes _____ No

Describe_____

Prior years illnesses_____

Past history of accident/trauma _____Motor Vehicle _____Industrial _____Other

Date of last Physical Exam_____ is there a chance that you are pregnant? _____Yes _____ No

Have you had X-rays/MRI/CT taken? _____ Yes _____ No If yes, where?_____

Are you taking any medications? Yes No (If yes, ask for form to fill out) Are you taking vitamins/Herbs/Minerals? Yes No

Do you have Allergies / Sensitivities? _____ Food _____ Environment _____ Medication

_____

_____

Have you been to a Chiropractor before? _____ Yes _____ No When_____

Explain_____

Have you ever:	**Yes**	**No**	**Briefly Explain**
Broken Bones?	_____	_____	_____
Been Hospitalized?	_____	_____	_____
Been in an Auto Accident?	_____	_____	_____
Had Sprains / Strains?	_____	_____	_____
Been struck unconscious?	_____	_____	_____
Had Surgery?	_____	_____	_____

Family History

Family Member Present and past health conditions (Example: heart disease, cancer, diabetes, arthritis, etc)

_____

_____

Stress Level	**Family**	**Severe**	**Moderate**	**Minimal**	**None**
	Job	_____	_____	_____	_____
	Other	_____	_____	_____	_____
	Explain Other	_____			

Are you nervous/anxious/depressed _____

Habits	**None**	**Light**	**Moderate**	**Heavy**
Alcohol	_____	_____	_____	_____
Coffee	_____	_____	_____	_____
Tobacco	**Never_____**	**Former_____**	**Current_____**	
Drugs	_____	_____	_____	_____
Exercise	_____	_____	_____	_____
Sleep	_____	_____	_____	_____
Appetite	_____	_____	_____	_____
Soft Drinks	_____	_____	_____	_____
Water	_____	_____	_____	_____
Salty Foods	_____	_____	_____	_____
Sugary Foods	_____	_____	_____	_____
Artificial Sweeteners	_____	_____	_____	_____

What do you do to stay healthy: (eg) Exercise, Vitamins, etc._____

_____

_____

_____

_____

_____

_____

	Yes	**No**
Do you experience pain everyday?	_____	_____
Do your symptoms interfere with daily life?	_____	_____
Does pain wake you up at night?	_____	_____
Are your symptoms worse during certain times of the days?	_____	_____
Do changes in weather affect your symptoms?	_____	_____
Do activities aggravate your symptoms?	_____	_____

What do you believe is wrong with you? _____

_____

_____

_____

_____

_____

_____