Wilhelm CHIROPRACTIC

Health History

Last Name_____ First Name_____ D.O.B._____

Primary Reason for Visit.

_____

_____

Primary Care Physician_____ Last Exam_____

Height_____ Weight_____ Gender_____

Any allergies to any medications, if so please list them below.

_____

_____

_____

List of Medication, Dosages, and Frequency.

_____

_____

_____

_____

_____

Do you smoke? **YES** **NO** Tobacco?_____ Type/Amount_____

Do you consume alcohol? **YES** **NO**

Please Circle the ones that apply to you.

High blood pressure	Heart/Vascular disease	Stroke	High Cholesterol	Asthma
Sinus Congestion	Emphysema	Recurring Headaches	Migraines	Seizures
Allergies/hay fever	Anemia	Anxiety/ Depression	Physical disorders	Arthritis
Joint/Muscle Pain	Kidney/bladder problems	Cancer	Fever	Diabetes
Thyroid disease	Bleeding/Clotting disorders	Broke Bones	Surgeries	

Please explain any conditions that you circled.

_____

_____

_____

_____

Family Health History

	Mother	Father	sibling	Son	Daughter
Arm Pain					
Arthritis					
Asthma					
ADD/ADHD					
Allergies					
Back Trouble					
Cancer					
Carpal Tunnel					
Diabetes					
Disc Problems					
Fibromyalgia					
Headaches					
Heartburn					
High Blood Pressure					
Hip Pain					
Leg Pain					
Menstrual Disorder					
Migraines					
Neck Pain					
Scoliosis					
Shoulder Pain					
Sinus Trouble					
Heart Disease					