Past Medical History

Patient Name (Last, First)	*Date*

General Health Questions (If you answered yes, please circle all that apply)	**Yes**	**No**
Have you experienced any: *unexplained weight loss | drop in energy | fever*	□	□
Are you currently pregnant and/or nursing? If yes: _____ weeks?	□	□
Are you currently taking oral contraceptives?	□	□
Are you currently taking any: *supplements | prescriptions | other medications*	□	□
*Please list all:		
Previous Chiropractic Care	**Yes**	**No**
Have you seen a chiropractor previously? How long ago? ___ mos ___ yrs	□	□
What techniques/therapies were utilized/effective for you?		
Social Health Questions	**Yes**	**No**
Do you exercise? How many days per week? ___ days, ___ min per day	□	□
Do you smoke? How many packs per day? ___ / day; How many years? ___	□	□
Do you use any recreational drugs? Please list all:	□	□
Health History Questions (If you answered yes, please circle all that apply)	**Yes**	**No**
Have you had any: *major accidents | traumas | major injuries*	□	□
*Please list all incidents and years:		
Have you had any: *hospitalizations | overnight stays in the ER | major surgeries*	□	□
*Please list all incidents and dates/years:	□	□
Have you ever had any major illnesses? Please list all:	□	□

Please check all that apply:

Medical Condition	**Yes**	**No**	**Medical Condition**	**Yes**	**No**
Abdominal pain	□	□	Fibromyalgia	□	□
Allergies/Asthma	□	□	Heart disease	□	□
Arthritis	□	□	Herniated Disc	□	□
Auto-Immune Disorder	□	□	High blood pressure	□	□
Cancer/Tumor	□	□	High cholesterol	□	□
Chest Pain (Angina)	□	□	Multiple sclerosis	□	□
Depression/Anxiety	□	□	Pacemaker	□	□
Diabetes: *Type I | Type II*	□	□	Other:	□	□

Relevant Family History

Please list all major diseases/disorders associated with any family members

Signature

Patient / Parent / Guardian Signature	*Date of Signature*

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