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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