CONFIDENTIAL MEDICAL HISTORY

PLEASE PRINT

Name _____ Date _____

Purpose of this appointment (Major Complaint):

_____

_____

_____

What activities aggravate your condition? _____

Is this condition getting progressively worse? YES_____NO _____CONSTANT _____COMES AND GOES_____

Is this condition interfering with your: WORK _____ SLEEP _____ DAILY ROUTINE _____ OTHER _____

How long has it been since you really felt good? _____

What do you believe is wrong with you? _____

Is condition due to injury or sickness arising out of your employment? _____

Date symptoms appeared or accident occurred : _____ Lost time from work : _____

Is condition due to an auto accident? _____ Date and Place of accident :_____

Have you ever had similar condition? _____ If yes, describe & give dates: _____

_____

Have you been treated for any health conditions by a physician in the last year? YES _____ NO _____

Describe condition: _____

Date of last examination: _____ X-rays: _____ Area x-rayed:_____

Have you ever been under Chiropractic care? _____ Name of Doctor: _____

Dates of treatment: _____ Condition treated: _____

List operations & dates: _____

List serious illnesses & dates: _____

List fractures & dates: _____

List medications or drugs you are taking: _____

List vitamins, herbal or other supplements you are taking: _____

Are you pregnant? _____ Birth Control : _____ Date Last menstrual period : _____

Do you smoke? _____ How much? _____ Do you drink alcohol? _____How much? _____ Caffeine? _____

Do you exercise? _____ Type of exercise? _____Frequency? _____

_____