Past Health History

NAME: **DATE:**

DOB: Height: Weight: Marital Status: # of Children:

Use of Tobacco: Y N Amount: Use of Alcohol: Y N Amount:

Use of Rec Drugs: Y N Amount: Use of Caffeine Y N Amount:

Highest Level of Education:

Current Job Description:

Current Level of Recreation:

Illness and Treatment

Prior to your present complaint, please list and describe all illnesses, accidents, treatments and effectiveness for each; list the year of each if possible:

Past Surgery

Please list all Surgeries, and outcomes:

Hospitalizations

Please list all hospitalizations, reasons, and outcomes:

Previous Medical/Chiropractic Treatment

Please list all treatments from any doctors or therapists:

Other Doctors Seen

Please list all doctors and dates last seen:

Medications

Please list all prescription medications and indicate presently taking or previously:

Supplements

Please list all vitamins, minerals and supplements and indicate presently taking or previously:

Allergies

Please list all items to which you have an allergic response of any kind:

Family History

Please indicate if your father, mother, sibling and/or grandparent had any of the following:

Arthritis:

Diabetes:

Heart Disease:

Cancer:

Kidney Disease:

High Blood Pressure:

Thyroid Disease:

Seizures:

Migraine:

Asthma:

Emphysema: