CHIROPRACTIC
Healthcare Center

HEALTH HISTORY

Place a check mark to indicate if you have or had any of the following:

□AIDS/HIV □Alcoholism □Allergy Shots □Anemia □Anorexia □Appendicitis □Arthritis □Asthma □Bleeding Disorders □Breast Lump □Bronchitis □Bulimia □Cancer □Cataracts □Chemical Dependency □Chicken Pox □Diabetes	□Emphysema □Epilepsy □Fractures □Glaucoma □Goiter □Gonorrhea □Gout □Heart Disease □Hepatitis □Hernia □Herniated Disk □Herpes □High Cholesterol □Kidney Disease □Liver Disease □Measles □Migraine Headaches	□Miscarriage □Mononucleosis □Multiple Sclerosis □Mumps Osteoporosis □Pacemaker □Parkinson's Disease □Pinched Nerve □Pneumonia □Polio □Prostate Problems □Prosthesis □Psychiatric Care □Rheumatoid Arthritis □Rheumatic Fever □Scarlet Fever □Stroke □Suicide Attempt	□Thyroid Problems □Tonsillitis □Tuberculosis □Tumors, Growth □Typhoid Fever □Ulcers □Vaginal Infections □Venereal Disease □Whooping Cough □Other:_____ _____ _____ _____

EXERCISE	**WORK ACTIVITY**	**HABITS**
□None	□Sitting	□Smoking Packs/Day_____
□Moderate	□Standing	□Alcohol Drinks/Day_____
□Daily	□Light Labor	□Coffee/Caffeine Drink/Cups/Day_____
□Heavy	□Heavy Labor	□High Stress Level Reason_____

Are you pregnant? □Yes □No Due Date?

Injuries / Surgeries You have had:	**Description**	**Date**
Motor Vehicle Accident :	_____	_____
Head Injuries :	_____	_____
Broken Bones :	_____	_____
Falls:	_____	_____
Surgeries:	_____	_____

MEDICATIONS	**ALLERGIES**	**VITAMINS / HERBS / MINERALS**
_____	_____	_____
_____	_____	_____
Pharmacy Name_____	_____	_____
Pharmacy Phone:	_____	_____
_____		

Signature: _____ Date: _____