Does it hurt to:	Walk	YES	NO	Do Housework	YES	NO	
	Sit	YES	NO	Drive	YES	NO	
	Stand	YES	NO	Exercise	YES	NO	
	Lift	YES	NO	Sleep	YES	NO	
	Climb	YES	NO	Take care of dependant's	YES	NO	
	Get out of bed	YES	NO				

Health History:

What treatment have you already received for your condition?

Medications Surgery Physical Therapy Chiropractic None Other_____

Name and address of other doctor(s) who have treated you for your condition _____

_____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____

Spinal Exam _____ Chest X-Ray _____ Urine Test _____

Dental X-Ray _____ MRI, CT-Scan, Bone Scan_____

Are you pregnant? YES NO If yes, what is the date of your last menstrual period_____

Place a mark on "YES" or "NO" to indicate if you have had any of the following.

AIDS/HIV	Yes	No	Emphysema	Yes	No	Migraine Headaches	Yes	No	Sexually transmitted disease	Yes	No
Alcoholism	Yes	No	Epilepsy	Yes	No	Miscarriage	Yes	No			
Allergy Shots	Yes	No	Fractures	Yes	No	Mononucleosis	Yes	No			
Anemia	Yes	No	Glaucoma	Yes	No	Multiple Sclerosis	Yes	No	Stroke	Yes	No
Anorexia	Yes	No	Goiter	Yes	No	Mumps	Yes	No	Suicide attempt	Yes	No
Appendicitis	Yes	No	Gonorrhea	Yes	No	Osteoporosis	Yes	No			
Arthritis	Yes	No	Gout	Yes	No	Pacemaker	Yes	No	Thyroid problems	Yes	No
Asthma	Yes	No	Heart Disease	Yes	No	Parkinson's Disease	Yes	No			
Bleeding Disorder	Yes	No	Hepatitis	Yes	No	Pinched Nerve	Yes	No	Tonsillitis	Yes	No
Breast Lump	Yes	No	Hernia	Yes	No	Pneumonia	Yes	No	Tuberculosis	Yes	No
Bronchitis	Yes	No	Herniated Disk	Yes	No	Polio	Yes	No	Tumors	Yes	No
Bulimia	Yes	No	Herpes	Yes	No	Prostate Problems	Yes	No	Typhoid fever	Yes	No
Cancer	Yes	No	High Blood Pressure	Yes	No	Prosthesis	Yes	No			
Cataracts	Yes	No	High Cholesterol	Yes	No	Psychiatric Care	Yes	No	Ulcers	Yes	No
Chemical Dependency	Yes	No	Kidney Disease	Yes	No	Rheumatoid Arthritis	Yes	No	Vaginal infection	Yes	No
			Liver Disease	Yes	No	Rheumatic Fever	Yes	No			
Chicken Pox	Yes	No	Measles	Yes	No	Scarlet Fever	Yes	No	Whooping cough	Yes	No
Diabetes	Yes	No	Other	Yes	No	_____					

Exercise:

____None
____Moderate
____ Daily
____Heavy

Work Activity:

____Sitting
____Standing
____Light Labor
____Heavy Labor

Habits:

____Alcohol Drinks/Week_____
____Coffee/Caffeine Cups/Day_____
____High Stress Level Reason_____
____Smoking Packs/Day_____

Are you aware of the negative effects of smoking?
YES NO

Are you aware that you can seek medical care to help you stop smoking? YES NO

Height_____
Weight_____
B.P._____

Medications	Allergies	Vitamins/Herbs/Minerals

List Surgeries:

_____Date_____ _____Date_____
_____Date_____ _____Date_____
_____Date_____ _____Date_____

Signature:_____Date_____