Health History

Height: _____Weight: _____ BMI: _____ Smoker: Yes / No

What medications do you take, reasons, and date started? Example: nerve pills, pain killers, aspirin, muscle relaxers, stimulants, blood thinners, tranquilizers, cholesterol, insulin: _____
_____

Who is your medical doctor? _____

What supplements do you take? None _____
_____

Family History: Cancer Diabetes High Blood Pressure Heart Problems Arthritis
Other_____

Patient History: Do you have/had the following conditions: (circle all that apply)

Heart Attack/Stroke	Heart Surgery/Pacemaker	Heart Murmur	Mitral Valve Prolapse
Alcohol/Drug Abuse	Hepatitis/HIV+/Aids	Prostate Problems	Cancer/Chemotherapy
Arthritis	Severe/Frequent Headaches	Psychiatric Problems	Kidney problems
High/Low Blood Pressure	Ulcers/Colitis	Sinus problems	Fainting/Seizures/Epilepsy
Asthma/Breathing problems	Diabetes/Tuberculosis	Artificial Joints	Birth Control Pills

Other medical conditions/Illnesses:_____
_____
Hospitalizations:_____
Allergies: food, medicine, seasonal, other:_____
List all surgeries:_____
List all accidents:_____

Are you interested in Nutritional Advice? Yes / No **Are you interested in Weight Loss?** Yes / No
Do you Exercise? Yes / No
Do you have Orthotics or arch supports? Yes / No **Do you need new Orthotics?** Yes / No
Is your mattress comfortable? Yes / No **Do you sleep on a cervical pillow?** Yes / No
Are you pregnant? Yes / No weeks: _____ **Breastfeeding?** Yes / No

Have you ever seen a Chiropractor before? Yes / No Whom? _____
Was it for the same problem? _____ Did you get relief? _____

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any change to the information that I have provided.

Signature:_____Date:____/_____/_____