

PLEASE FILL OUT THIS FORM COMPLETELY
PERSONAL HISTORY

NAME: _____ DATE: ___/___/___ SS# _____

ST. ADDRESS: _____ TOWN: _____ STATE: _____ Zip: _____

PHONE#: (_____) _____ Date of Birth: ___/___/___ AGE: _____ Sex: M F

E-Mail: _____ Race: _____ Ethnicity: _____

Emergency Contact: : _____ Phone: (_____) _____ Preferred Language: _____

Referred to office by: _____

Insurance Co: _____ Policy # _____

Employer: _____ Address: _____ Phone#: _____

CURRENT HEALTH CONDITION

Current Problem: _____ Other Doctors seen for condition: _____

Current Medical Physician : _____ Previous Chiropractor: _____ Last visit _____

<u>Current Medications</u>	<u>Dosage</u>	<u>Medication</u>	<u>Dosage</u>	<u>Medication</u>	<u>Dosage</u>
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Drug Allergies:

SOCIAL HISTORY

Circle one: Married Single Widowed Divorced No. of children: _____

Non-smoker Former smoker Current smoker # packs/day _____

Average amount of alcohol: _____ Day/week/month/year

Job Title: _____

PAST SURGICAL HISTORY

Major Surgery/Operations: _____

Appendectomy Tonsillectomy Gall Bladder Hernia Hysterectomy

ACCIDENTAL HISTORY

Major Accidents or Falls: _____

PAST HEALTH HISTORY

- | | | | |
|---|---|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Emphysema | <input type="checkbox"/> M. S. | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Mumps | <input type="checkbox"/> Venereal DZ |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Fever Blisters | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Whooping |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Goiter | <input type="checkbox"/> Pleurisy | Others: |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Gout | <input type="checkbox"/> Pnuemonia | _____ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Dz | <input type="checkbox"/> Polio | _____ |
| <input type="checkbox"/> Clotting | <input type="checkbox"/> Influenza | <input type="checkbox"/> Rheumatic | _____ |
| <input type="checkbox"/> Cold Sores | <input type="checkbox"/> Lumbago | <input type="checkbox"/> Fever | _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Malaria | <input type="checkbox"/> Stroke | _____ |
| <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Measles | <input type="checkbox"/> Tuberculosis | _____ |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Typhoid | _____ |

Multimeddocs/history intake