Medical History Information

Last Name:		❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one)
First Name:	Middle:			Single / Mar / Div / Sep / Widow

Email:	Birth date:	Age:	Sex:

Address:	City:

State:	Zip Code:	Home Phone:

Cell Phone:	Would you like appt. reminders?	If yes, cell phone carrier:

Do you have health insurance/PIP?	If yes, insurance company name:
Policy/Accident Claim #:	Referred By:

Medical Care Information

Do You Have a Family Doctor?: No Yes, Name of Doctor:

Address:	City:	State:	ZIP Code:

Date of last Visit: / /	Date of last exam: / /

Do You Have a Family Chiropractor?: No Yes, Name of Chiropractor:

Address:	City:	State:	ZIP Code:

Date of last Visit: / /	Date of last exam: / /

Have you had surgeries? Yes No If yes, Last Surgery Date:

Reason for Surgery:

Present illness /Conditions:

AIDS	Cancer	Heart Problem	Multiple Sclerosis	Spinal Disc Disease	
Allergies	Cirrhosis/hepatitis	High blood pressure	Pacemaker	Thyroid trouble	Epilepsy
Anemia	Diabetes	HIV/ARC	Prostate trouble	Tuberculosis	
Arthritis	Dislocated joints	Kidney trouble	Rheumatic fever	Ulcer	
Asthma	Diverticulitis	Low Blood Pressure	Scoliosis	Polio	
Bone fracture	Hay Fever	Mental/ Emotional Difficulty	Sinus trouble	STD’S	

Other:

Family History of illness:

AIDS	Cancer	Multiple Sclerosis	Spinal Disc Disease	STD’S	
Allergies	Bone fracture	Heart Problem	Low Blood Pressure	Sinus trouble	Ulcer
Anemia	Cirrhosis/hepatitis	HIV/ARC	Mental/ Emotional Difficulty	Epilepsy	Polio
Arthritis	Diabetes	High blood pressure	Prostate trouble	Thyroid trouble	Scoliosis
Asthma	Dislocated joints	Kidney trouble	Rheumatic fever	Tuberculosis	Diverticulitus

Other:

Social History:			
Alcohol? No Yes Drinks per week?	Cigarettes? No Yes Packs per day?	Caffeine? No Yes Drinks per day?	Exercise? No Yes Hours per week? (circle one) Light / Moderate / Strenuous

Signature: ____ Date: __________________

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.