

Medical History Information

Last Name:		Middle:		<input type="checkbox"/> Mr.	<input type="checkbox"/> Miss	Marital status (circle one)	
First Name:				<input type="checkbox"/> Mrs.	<input type="checkbox"/> Ms.	Single / Mar / Div / Sep / Widow	
Email:				Birth date:		Age:	Sex:
Address:				City:		State:	
ZIP Code:		Social Security No.:		Home Phone:			
Occupation:		Employer:			Employer phone:		
Employer Address:							
What do your daily work habits include? (Ex: Sitting, Light Labor, Heavy Labor, Computer Work)				WOMEN ONLY		Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No	
						Nursing? <input type="checkbox"/> Yes <input type="checkbox"/> No	
						Taking birth control pills? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Please list all medications or any special diet you are currently on:				What vitamins and/or nutritional supplements do you take? (if any)			
Whom may we thank for referring you to us?							
Medical Care Information							
Is your visit due to an injury? <input type="checkbox"/> Work-Related <input type="checkbox"/> Sports Injury <input type="checkbox"/> Chronic Injury <input type="checkbox"/> Other _____				What treatment have you already received? <input type="checkbox"/> Medication <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Surgery <input type="checkbox"/> Other _____			
Do you have a Family Doctor ? <input type="checkbox"/> No <input type="checkbox"/> Yes, Name of Doctor: _____				Date of last exam: / /			
Address:		City:		State:		ZIP:	
Do You Have a Family Chiropractor ? <input type="checkbox"/> No <input type="checkbox"/> Yes, Name of Chiropractor: _____				Date of last exam: / /			
Address:		City:		State:		ZIP:	
Additional Doctor ?: <input type="checkbox"/> No <input type="checkbox"/> Yes, Name of Doctor: _____				Date of last exam: / /			
Address:		City:		State:		ZIP:	
Additional Doctor ?: <input type="checkbox"/> No <input type="checkbox"/> Yes, Name of Doctor: _____				Date of last exam: / /			
Address:		City:		State:		ZIP:	
Additional Doctor ?: <input type="checkbox"/> No <input type="checkbox"/> Yes, Name of Doctor: _____				Date of last exam: / /			
Address:		City:		State:		ZIP:	
Have you had surgeries in the last 5 Years: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Last Surgery Date: _____							
Reason for Surgery: _____							
Present Illness /Conditions:							
<input type="checkbox"/> AIDS	<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart Problem	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Spinal Disc Disease			
<input type="checkbox"/> Allergies	<input type="checkbox"/> Cirrhosis/hepatitis	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Thyroid trouble	<input type="checkbox"/> Epilepsy		
<input type="checkbox"/> Anemia	<input type="checkbox"/> Diabetes	<input type="checkbox"/> HIV/ARC	<input type="checkbox"/> Prostate trouble	<input type="checkbox"/> Tuberculosis		<input type="checkbox"/>	
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Dislocated joints	<input type="checkbox"/> Kidney trouble	<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Ulcer		<input type="checkbox"/>	
<input type="checkbox"/> Asthma	<input type="checkbox"/> Diverticulitis	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Scoliosis	<input type="checkbox"/> Polio		<input type="checkbox"/>	
<input type="checkbox"/> Bone fracture	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Mental/ Emotional Difficulty	<input type="checkbox"/> Sinus trouble	<input type="checkbox"/> STD'S		<input type="checkbox"/>	
Other: _____							
Social History:							
Alcohol? <input type="checkbox"/> No <input type="checkbox"/> Yes Drinks per week?		Cigarettes? <input type="checkbox"/> No <input type="checkbox"/> Yes Packs per day?		Caffeine? <input type="checkbox"/> No <input type="checkbox"/> Yes Drinks per day?		Exercise? <input type="checkbox"/> No <input type="checkbox"/> Yes, Hours per week? (circle one) Light / Moderate / Strenuous	
An IMPORTANT part of your care will be understanding your condition, how to support healing and avoid relapse. What method would be most convenient for you to learn this information?				<input type="checkbox"/> Attend a one-time Spinal Care Class <input type="checkbox"/> Email me one lesson at a time			

Signature: _____

Date: _____

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