Patient Health History CONFIDENTIAL

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Name_____ Date_____

Home Address_____

City_____ State_____ Zip_____

Home Phone_____ E-mail_____

Cell Phone_____ Occupation_____

Emergency Contact: Name_____ Phone_____

Who should we thank for referring you to this office? _____

Where did you find out about us? _____

Sex: Male Female Height____ Weight_____ Birth date_____ Age_____

Marital Status: Married Single Divorced Widowed # of children _____

Have you received chiropractic, acupuncture or herbal therapy before? Yes No

When? _____ With whom? _____

Who is your primary care Doctor? _____

Please indicate any illness you or a blood relative (grandparent, parent or sibling) have had:

	You	Your relative	Approx. Date
Cancer	___	___	_____
Hepatitis	___	___	_____
High Blood Pressure	___	___	_____
Rheumatic Fever	___	___	_____
Infectious Diseases	___	___	_____
Diabetes	___	___	_____
Heart Disease	___	___	_____
Seizures	___	___	_____
Emotional Disorders	___	___	_____
Tuberculosis	___	___	_____

STDS: Gonorrhea___ Syphilis___ HIV___ HPV___ Chlamydia___ Herpes___ Date_____

List any medications and supplements you are currently taking:

Medicine	Reason	Prescribed by	Dates
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please indicate frequency of the following:

	Yes	No	How Much		Yes	No	How much		Yes	No	How much
Coffee	___	___	_____	Tobacco	___	___	_____	Water intake	___	___	_____
Drugs	___	___	_____	Alcohol	___	___	_____	Soda Pop	___	___	_____
Exercise	___	___	_____	Sleep	___	___	_____	Sugar	___	___	_____

What are the main problems for which you are seeking treatment?

_____
_____
_____

What other forms of treatment have you sought?

_____
_____
_____

List any other health concerns that you have:

_____
_____
_____

Do you have any known allergies?

_____
_____
_____

List any accidents, surgeries or hospitalizations (please include dates):

_____
_____
_____

Please list any lab results and date of last blood test:

_____
_____
_____

How do you feel about the following areas of your life?

	Great	Good	Fair	Poor	Bad	Your Comments
Significant other	___	___	___	___	___	_____
Family	___	___	___	___	___	_____
Diet	___	___	___	___	___	_____
Sex	___	___	___	___	___	_____
Self	___	___	___	___	___	_____
Work	___	___	___	___	___	_____
Exercise	___	___	___	___	___	_____
Spirituality	___	___	___	___	___	_____