PERSONAL HISTORY

NAME: _____ SOCIAL SECURITY #: ____-____-____

ADDRESS: _____ CITY: _____ ZIP CODE: _____

HOME PHONE: _____ WORK PHONE: _____

DATE OF BIRTH: ____/____/____ MARITAL STATUS: ❑ S ❑ M ❑ D SEX: ❑ M ❑ F

EMPLOYERS NAME: _____ OCCUPATION: _____

EMPLOYERS ADDRESS: _____ CITY: _____ ZIP CODE: _____

HEALTH HISTORY

HAVE YOU EVER BEEN TREATED BY A CHIROPRACTOR BEFORE: ❑ YES ❑ NO

WHAT IS YOUR CHIEF COMPLAINT? _____

IS IT A RESULT OF AN ACCIDENT/FALL? ❑ YES ❑ NO IF YES, WHEN? ____/____/____

HAVE YOU SEEN ANY OTHER HEALTH PROFESSIONAL REGARDING THIS PROBLEM? ❑ YES ❑ NO

IS THE CONDITION GETTING WORSE? ❑ YES ❑ NO

IS THE CONDITION INTERFERING WITH YOUR? ❑ WORK ❑ SLEEP ❑ EATING ❑ DAILY ROUTINE

HAVE YOU HAD THIS, OR SIMILAR CONDITION(S) IN THE PAST? ❑ YES ❑ NO

IF YES, PLEASE EXPLAIN: _____

PLEASE LIST ANY SURGERIES: _____

ANY BROKEN BONES? ❑ NO ❑ YES: _____

PLEASE LIST ANY PRESENT MEDICATION (S): _____

_____

WHAT EXERCISE ROUTINES DO YOU HAVE? _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASE/MEDICAL CONDITION(S):

( ) HEART ATTACK/STROKE	( ) LOWER BACK PROBLEMS	( ) ARTIFICIAL BONES/JOINTS
( ) CONGENITAL HEART DEFECT	( ) HEART SURGERY/PACEMAKER	( ) HEART PROBLEMS
( ) HIV+/AIDS	( ) SHINGLES	( ) SKIN RASH
( ) FREQUENT NECK PAIN	( ) EMPHYSEMA/GLAUCOMA	( ) HEMATOMA
( ) HIGH/LOW BLOOD PRESSURE	( ) EDEMA/SWELLING	( ) CONSTIPATION
( ) SEVERE/FREQUENT HEADACHES	( ) VARICOSE VEINS	( ) HEPATITIS
( ) DIZZINESS	( ) CHRONIC FATIGUE	( ) CANCER
( ) LEG PAIN	( ) PSYCHIATRIC PROBLEMS	( ) ANEMIA
( ) SURVIVOR OF ABUSE	( ) KIDNEY PROBLEMS	( ) ULCERS
( ) FAINTING/SEIZURES/EPILEPSY	( ) SINUS/ALLERGY PROBLEMS	( ) ASTHMA
( ) DIABETES/TUBERCULOSIS	( ) DIFFICULTY BREATHING	( ) ARTHRITIS