PERSONAL HISTORY

Patient Account #_____ Date:_____

First Name:_____ Last Name: _____

Street Address: _____

City:_____ State:_____ Zip: _____

Home Phone:_____ Social Security No.: _____

In Case of Emergency, contact:_____ Phone No.:_____

Marital Status: M / S / D / W / Sep Birth Date:_____ Ht.:_____ Wt.: _____

Employer:_____ Occupation: _____

Employer Street Address: _____

City:_____ State:_____ Zip: _____

Work Phone: _____ Complaint / How Long: _____

_____

Is this visit the result of ☐ Accident or ☐ Injury? Please explain: _____

_____

What other doctors have you seen for this condition? _____

Have you had previous chiropractic care? ☐Yes ☐ No If so, give name & location:_____

_____

If so, were x-rays taken? ☐Yes ☐ No Results of Previous Care: _____

What medications, if any, are you currently taking? _____

How were you referred to this office? _____

PAST HEALTH HISTORY

Operations - Please check all that apply:

☐ Appendix	☐ Rectal	☐ Tonsils	☐ Gall Bladder	☐ Female Organs
☐ Hernia	☐ Joints	☐ Heart	☐ Spine	☐ Implants
☐ Pacemaker	Any other surgical procedures:_____			

Accidents or Falls - Please describe _____

_____

Broken Bones of Dislocations - _____

Diseases - Please check any that you have had:

☐ Appendicitis	☐ Malaria	☐ Chicken Pox	☐ Alcoholism
☐ Scarlet Fever	☐ Tuberculosis	☐ Diabetes	☐ Venereal Infection
☐ Diphtheria	☐ Whooping Cough	☐ Cancer	☐ Arthritis
☐ Typhoid Fever	☐ Anemia	☐ Heart Disease	☐ Epilepsy
☐ Pneumonia	☐ Measles	☐ Goiter	☐ Lumbago
☐ Mental Disorder	☐ Mumps	☐ Influenza	☐ Polio
☐ Small Pox	☐ Pleurisy	☐ Eczema	☐ Mental Breakdown
☐ Rheumatic Fever	☐ Other:_____		