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:	Social Security No.:	Home Phone:			
Occupation:	Employer: Phone:			Cell phone:	

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: / /		
Have You Had Chiropractic Care In The Past? ☐ No ☐ Yes, Name of Chiropractor:			
Address:	City:	State:	ZIP Code:
Date of last Visit: / /	Date of last exam: / /		
Have you had surgeries in the last 5 Years: ☐ 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	☐ Currently Pregnant Due Date:	☐ Taking Birth Control
☐ Anemia	☐ Diabetes	☐ HIV/ARC	☐ Prostate trouble	☐ Tuberculosis	☐ Date of Last Cycle
☐ Arthritis	☐ Dislocated joints	☐ Kidney trouble	☐ Rheumatic fever	☐ Thyroid trouble	☐ Ulcer
☐ Asthma	☐ Diverticulitis	☐ Low Blood Pressure	☐ Scoliosis	☐ Epilepsy	☐ 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:

Type of Cancer: ☐ Breast ☐ Lung ☐ 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

Misc.:

Signature: _____ Date: _____

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

MH-0001