

Date: _____

File No. _____

Confidential Personal History

(Please Print)

Name _____ Marital: M S W D SSN _____

Address _____ Home Phone _____ Sex _____

City _____ State _____ Zip _____ Office Phone _____ Birth Date _____

Name of Wife or Husband _____ E-Mail _____ Age _____

Referred by _____ Number of Children _____

Occupation or Profession _____ Employed By _____

Previous Chiropractic Care? Yes No If Yes, with Whom _____

Name of Family Physician _____

Do you have health insurance? Yes No What Company? _____

Present Complaint (Explain) _____

Cause _____ Date of Onset _____ Duration _____

Treatment thus far for this complaint _____

Do not write in this space

Physician:

History: Injuries, (Auto, Work Related, Etc.) Please Explain _____

Check the Following Illnesses that you have had in the past:

- | | | | |
|---|---------------------------------------|---|--|
| <input type="checkbox"/> Measles | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Mumps | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Syphilis | <input type="checkbox"/> Nervous Breakdown |
| <input type="checkbox"/> Chickenpox | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Gall Stones | <input type="checkbox"/> "Leaking" Heart (Murmurs) |
| <input type="checkbox"/> Smallpox | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Rheumatic Fever (Chorea) |
| <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Hepatitis or Jaundice |
| <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Goiter | <input type="checkbox"/> Cancer | <input type="checkbox"/> Hives or Eczema |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Migraine | <input type="checkbox"/> Meningitis | <input type="checkbox"/> Any Bone or Joint Disease |
| <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Fractures | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Asthma | <input type="checkbox"/> Other _____ | |

Family History: Check those that apply:

	Living	Dead	Cancer	T.B.	Diabetes	Blood Disease	Allergy	Heart	Arthritis	Other
Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sisters	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Brothers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

I believe the front and back of this Confidential History to be true and accurate to the best of my knowledge.

PATIENT'S SIGNATURE _____ DATE _____

Surgical History: Put the year in front of those surgeries which you have had:

_____ Cholecystectomy (Gall Bladder)	_____ Hysterectomy (Uterine)	_____ Adenoidectomy
_____ Herniorrhaphy (Hernia)	_____ Prostatectomy (Prostate)	_____ Appendectomy
_____ Hemorrhoidectomy (Hemorrhoid)	_____ Tonsillectomy	_____ Vaginal Repair
<input type="checkbox"/> Other Surgery		

Current Symptoms: Check those that presently apply:

Skin	Weight	Throat	Stomach or Intestines
<input type="checkbox"/> Rashes	<input type="checkbox"/> Gain	<input type="checkbox"/> Soreness	<input type="checkbox"/> Poor Appetite
<input type="checkbox"/> Eruptions	<input type="checkbox"/> Loss	<input type="checkbox"/> Hoarseness	<input type="checkbox"/> Nausea
<input type="checkbox"/> Discolorations	<input type="checkbox"/> Remain the Same	<input type="checkbox"/> Difficulty Swallowing	<input type="checkbox"/> Vomiting
Head	Ears	Nose	<input type="checkbox"/> Belching
<input type="checkbox"/> Headaches	<input type="checkbox"/> Deafness	<input type="checkbox"/> Sinusitis	<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Trauma	<input type="checkbox"/> Discharge	<input type="checkbox"/> Bleeding	<input type="checkbox"/> Constipation
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Ringing	<input type="checkbox"/> Post Nasal Drip	<input type="checkbox"/> Hemorrhoids
<input type="checkbox"/> Fainting	<input type="checkbox"/> Excess Wax	<input type="checkbox"/> Obstruction	<input type="checkbox"/> Rectal Bleeding
Chest	Muscular	Urinary (Urination)	<input type="checkbox"/> Irregular Stool
<input type="checkbox"/> Pain	<input type="checkbox"/> Numbness	<input type="checkbox"/> Abnormally Frequent	<input type="checkbox"/> Hernia
<input type="checkbox"/> Heart Pounding	<input type="checkbox"/> Joint Pain	<input type="checkbox"/> Burning	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Difficulty Breathing	<input type="checkbox"/> Varicosities	<input type="checkbox"/> Pain	Habits
<input type="checkbox"/> Cough up Blood	<input type="checkbox"/> Swelling of Hand or Feet	<input type="checkbox"/> Discolored with Blood or Pus	<input type="checkbox"/> Coffee
Eyes	Female Only	<input type="checkbox"/> Complications during pregnancy	<input type="checkbox"/> Tea
<input type="checkbox"/> Double Vision	<input type="checkbox"/> Periods Irregular	<input type="checkbox"/> Menopause	<input type="checkbox"/> Milk
<input type="checkbox"/> Glasses	<input type="checkbox"/> Periods Regular		<input type="checkbox"/> Water
<input type="checkbox"/> Tearing	<input type="checkbox"/> Duration of Periods		<input type="checkbox"/> Fruit Juices
<input type="checkbox"/> Burning	___ Number of Pregnancies		<input type="checkbox"/> Alcohol
<input type="checkbox"/> Eye Strain			<input type="checkbox"/> Cigarettes
<input type="checkbox"/> Sensitive to Light			<input type="checkbox"/> Drugs (Pot etc.)
			<input type="checkbox"/> Diets
			<input type="checkbox"/> Other

Put an "X" on each line where it applies.

	Never	Occasionally	Frequently	Daily	
Laxatives _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Diuretics (Water Pills) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other Medications (please list)
Appetite Suppressants _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Vitamins _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Antibiotics _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Aspirin or Related Compounds _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sleeping Pills _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sedatives (Tranquilizers) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hypertensive Agents (Blood Pressure) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Digitalis _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Nitroglycerine _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cortisone, ACTH or Other Steroids _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Orinase, Diabinese _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Insulin _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other Hormones _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

X-Ray Survey:

Have you been X-rayed before? Yes No When? _____ How Many Times? _____

Where? _____ What Body Region? _____

Have you ever had X-Ray Treatments? Yes No When? _____ For how long? _____

Have you ever had Chemotherapy? Yes No When? _____ For how long? _____

FEMALES: Are you currently pregnant? Yes No Date of Last Menses _____