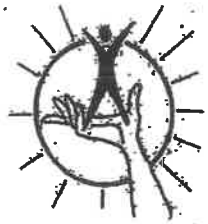


PATIENT HISTORY QUESTIONNAIRE

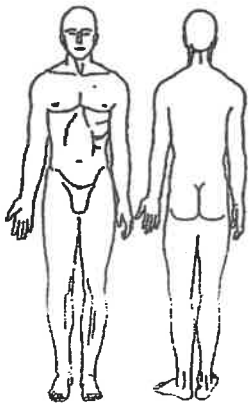
Date completed:_____

Please Print Clearly

Name: _____
Address: _____
City/State : _____
Zip Code: _____
Phone: (home) _____
(work) _____
Employer: _____
Occupation : _____
E-Mail: _____

Date of Birth: _____
Marital Status : M S D Sep W
Spouse's Name : _____
# of children : _____
# of pregnancies: _____
Who referred you to us? _____
Contact in emergency: _____
Phone # _____
Insurance Co. : _____
Policy #: _____

CURRENT PROBLEM (Please describe briefly, with date of onset, other doctors seen, diagnosis & treatment. We will discuss this fully in person. Mark areas of pain on figure.)



HAVE YOU EVER BEEN TREATED BY A CHIROPRACTOR?
FOR WHAT PROBLEM? WHEN? DID YOU GET GOOD RESULTS?

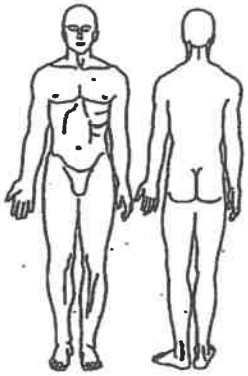
IN YOUR **WHOLE LIFE** HAVE YOU EVER HAD ANY OF THE FOLLOWING:

AUTO ACCIDENTS: (Please include date, what happened, what injuries, any X Rays taken, and treatment received.)

BAD FALLS, SPRAINS, STRAINS AND BLOWS TO THE HEAD: (describe as for accidents)

BROKEN BONES, FRACTURES: (date, what bone, any problems with healing?)

SURGERY:(include date, type of surgery, reason, complications, where done)
Please draw in all surgical and other scars on the figures



HOSPITALIZATIONS: (Date, what was wrong, what treatment)

SERIOUS ILLNESSES: (when? what treatment?)

Lung Disease	Autoimmune Disease
Heart Disease	Blood Disease / Anemia
Blood pressure problems	Sexually Transmitted Disease
Liver Disease	Neurological Disease / Stroke
Diabetes	Tumors
Kidney Disease	CANCER
Bone Disease	HIV / AIDS

FAMILY HISTORY: (List any close relatives who have had any of the above)

ARE YOU CURRENTLY UNDER ANY OTHER DOCTOR'S CARE (what condition? Treatment?

HEALTH EXAMINATIONS: When was your last physical exam?_____
Any problems found not previously noted?

NUTRITION AND DAILY HABITS

ARE YOU: _____OVERWEIGHT? _____UNDERWEIGHT? _____ JUST RIGHT?
Actual current weight:_____ What weight do you consider ideal for yourself?_____

ARE YOU ON ANY SPECIAL DIET? VEGETARIAN?

ON AN AVERAGE DAY WHAT DO YOU EAT FOR:
BREAKFAST?

LUNCH?

SUPPER?

SNACKS?

SWEETS? (servings of candy, cakes, cookies, pastry, etc. per day or week?)_____

BEVERAGES: (please note amounts in average day, week, etc.)

WATER:_____ COFFEE/TEA _____(decaf / regular?)
Water softener?_____(type)_____ MILK:_____(whole / 2% / skim?)
SODA:_____(regular / diet?) JUICE:_____
HERB TEA:_____(Type?) ALCOHOL:_____

DO YOU CRAVE ANY FOOD OR BEVERAGE:

DO YOU REACT BADLY TO ANY FOOD OR BEVERAGE? Known food allergy or intolerance?

SMOKING: Amount? Date quit?_____

ALCOHOL OR CHEMICAL DEPENDENCY:

SLEEP : How many hours do you sleep at night? _____ Any sleep difficulties?
Trouble falling asleep?____ Trouble staying asleep?____ Sleep not restful?_____

EXERCISE: Type? Frequency? Any problems?

DO YOU WEAR ANY TYPE OF ARCH SUPPORT OR ORTHOTIC? YES___ NO___

PLEASE MARK ANY CONDITIONS YOU HAVE NOW OR HAD IN THE PAST

Have you had any of the following tests? When? Where done? Results, if known?

EKG or Stress Test_____
Cholesterol/Triglycerides _____
Blood Chemistry or Screen_____
Blood sugar / HbA1C_____Urinalysis_____
Stool Analysis_____
(Women) Gynecologic Exam _____ Mammogram_____PapTest_____
(Men) Prostate Exam _____PSA_____
Dental_____Eye_____
X-RAYS: Spinal_____Chest_____Dental_____ Other_____

PLEASE EXPLAIN ANY POSITIVE FINDINGS ON LABS AND IMAGING:

VITAMINS, MINERALS, AND FOOD SUPPLEMENTS: (currently taken)

MEDICATIONS, DRUGS, OVER THE COUNTER REMEDIES TAKEN NOW: (what for? what medicine? side effects?)

PAST MEDICATIONS
(what? when?)

Hormones: __Thyroid
__Estrogen
__Progesterone
__Birth Control Pill
__Cortisone
__Testosterone
__Other_____

__Tranquilizers
__Antidepressants
__Anti inflammatory drugs
__Long course of antibiotics
__Allergy/Asthma medicine
__Allergy shots
__Blood pressure medication
__Heart medication

__Diet pills/Amphetamines
__Pain Killers / Analgesics
__Anti convulsants
__Chemotherapy
__Other_____

ALLERGIES TO DRUGS? YES NO

DRUG FIRST TIME REACTED TYPE OF REACTION

_____
_____
_____

MAJOR DENTAL WORK / BRACES / TMJ (JAW) PROBLEMS?

ANY LEARNING DISABILITY, DYSLEXIA, INCOORDINATION, OR CONFUSION?

HAVE YOU EVER BEEN UNCONSCIOUS? (Anesthetic, knocked out, fainted?)