SMITH AND JONES CHIROPRACTIC
CONFIDENTIAL HEALTH HISTORY

DATE:_____

Name:_____ Sex_____ Marital Status_____ DOB_____
First Name MI Last Name (Legal Name) (M/F) (MSDW)

Address_____ City_____ State_____ Zip_____ SS#_____

Phone#_____ Cell#_____ Who referred you to this office_____

Business Phone_____ Employer_____ Occupation_____
Spouse's Name_____ Spouse's SS#_____ Spouse's Employer_____
Spouse's Date Of Birth_____
Please list anyone we can speak to about your condition/treatment_____
_____

Do you use: Alcohol _____ Tobacco_____ Coffee_____ Height:_____ Weight:_____
Do you take vitamins?_____ If yes, what do you take?_____

Please describe the principal health problem for which you came to this office_____
_____

Date you first noticed symptoms_____

List any other doctors seen for this_____

List any diagnosis and/or treatment given_____

Have you lost any days of work for this condition?_____ Dates:_____

Have you had any similar accidents or injuries?_____ Please explain_____

List any relatives that have had a similar condition_____

Have you or any relative received chiropractic treatment previously?_____ Please explain_____

Have you been treated for any health condition by a physician in the past year?_____ Please explain_____
_____

Are you currently taking any medication?_____ If yes, please list_____

List any surgery or unusual diseases you have had (list dates)_____
_____

Have you or anyone in your family had a stroke, TIA, or stroke like symptoms?_____

Have you had rapid weight gain or loss in the past 6 months?_____

PLEASE FILL OUT THE BACK OF THIS FORM

PLACE AN "X" ON ANY PROBLEMS YOU ARE CURRENTLY HAVING

MUSCULO-SKELETAL

_____ Low back pain
_____ Pain between shoulders
_____ Neck pain
_____ Arm pain
_____ Leg pain
_____ Painful joints
_____ Muscle pain

GENITO-URINARY SYSTEM

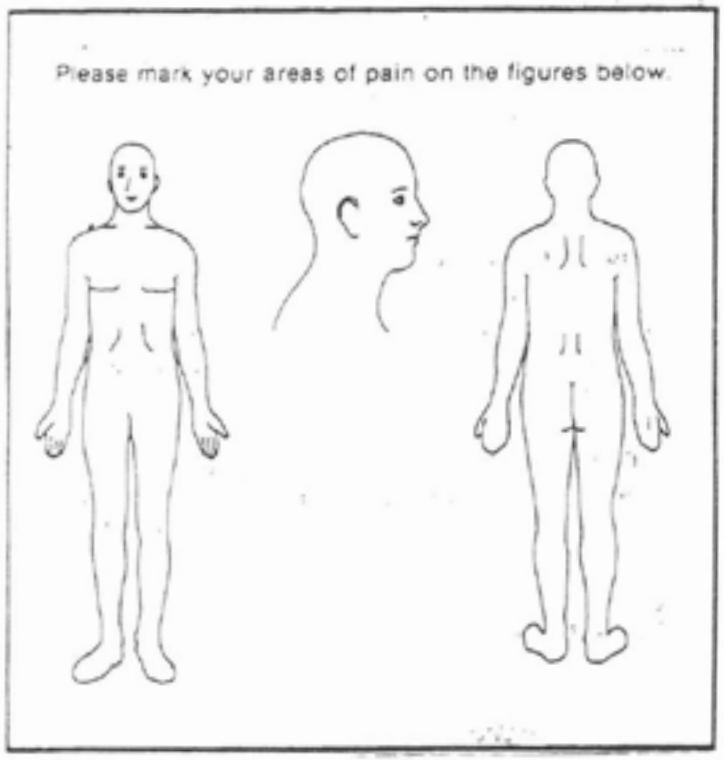
_____ Bladder trouble

FEMALE

_____ Vaginal problems
_____ Breast pain/lumps

ARE YOU PREGNANT?

_____Yes _____No



GASTRO-INTESTINAL SYSTEM

_____ Poor / excessive appetite
_____ Excessive hunger
_____ Excessive thirst
_____ Vomiting food/blood
_____ Diarrhea/constipation
_____ Black/bloody stool
_____ Hemorrhoids
_____ Liver trouble
_____ Gall bladder trouble

NERVOUS SYSTEM

_____ Numbness
_____ Dizziness
_____ Fainting
_____ Headaches
_____ Confusion
_____ Depression

CARDIO-VASCULAR SYSTEM

_____ **Pacemaker**
_____ Chest pain
_____ Difficult breathing
_____ Coughing blood
_____ Lung problems
_____ Heart problems

In case of emergency, please notify_____Telephone_____

I understand that this office will bill my insurance as a courtesy to me. I give permission to the doctor to release information requested by the insurance company concerning my health history, examinations and treatment. I hereby authorize and direct my insurance benefits to be paid directly to the doctor. I understand that I am responsible for all charges incurred in this office.

Though Chiropractic adjustments and treatments are usually beneficial and seldom cause any problem, I understand and am informed that there are some risks to treatment. Risks include, but are not limited to, fractures, disc injuries, strokes, dislocations, and sprains.

I verify that the above information which I have provided is correct. I also verify that I have read the above information, and that I am agreeable with it's contents. I also agree that no results are guaranteed.

_____Patient Signature