Patient Health Information

Patient Name _____ Date _____

Medical Screening

(Circle Yes or No)

Have you had chiropractic treatment in the last year? Yes No

Have you or any immediate family member been told you have:

	Self		Family			Self		Family	
Cancer	Yes	No	Yes	No	Diabetes	Yes	No	Yes	No
High Blood Pressure	Yes	No	Yes	No	Heart Disease	Yes	No	Yes	No
Angina/Chest Pain	Yes	No	Yes	No	Stroke	Yes	No	Yes	No
Osteoporosis	Yes	No	Yes	No	Tuberculosis	Yes	No	Yes	No
Arthritis	Yes	No	Yes	No					

Do you have a history of:

Allergies/Asthma	Yes	No	Headaches	Yes	No	Bronchitis	Yes	No
Kidney Disease	Yes	No	Rheumatic fever	Yes	No	Ulcers	Yes	No
Seizures	Yes	No	Hepatitis	Yes	No	Vertigo	Yes	No

In the past 3 months, have you had or do you experience:

A change in your health?	Yes	No	Nausea/vomiting?	Yes	No
Fever/chills/sweats?	Yes	No	Unexplained weight change?	Yes	No
Numbness/Tingling	Yes	No	Changes in appetite?	Yes	No
Difficulty in Swallowing?	Yes	No	Changes in bowel?	Yes	No
Shortness of Breath?	Yes	No	Changes in bladder function?	Yes	No

Are you currently:

Pregnant?	Yes	No
Depressed?	Yes	No
Under stress?	Yes	No
Have a pacemaker?	Yes	No

Do you or have you smoked tobacco? (please circle) Yes No

If yes, # pack/day _____ X # years _____

Last tobacco use _____

Do you drink alcohol? (Please Circle) Yes No

If yes, # drinks/week _____

THE ABOVE STATEMENTS ARE TRUE TO THE BEST OF MY KNOWLEDGE

Signature _____ Date _____