Supplemental Health History Form

Patient Signature: _____

1 Have you ever been to a chiropractor before?
Who? _____
When? _____
Results and impressions? _____

2 Have you ever been diagnosed with any major illnesses, including any of the following: ___ Yes ___ No

___ Congenital bone or joint disorder
___ Rheumatoid arthritis
___ Severe degenerative arthritis
___ History of compression fracture
___ History of heart attack
___ History of stroke or aneurysm
___ Past history of cancer or currently diagnosed with cancer
___ Diabetes with cold, burning, or numb feet
___ Ankylosing spondylitis
___ Immune suppression such as from chemotherapy, organ transplant, etc.
___ 3 or more months use of steroid medications or intravenous drugs (past or recent)
___ Gout
___ Lupus
___ HIV positive or AIDS
___ Emphysema
___ Liver disease
___ Congenital heart disorder
___ Seizure disorder
___ Tuberculosis
___ Severe gastrointestinal dysfunction
___ Kidney disease and / or bladder dysfunction
___ Other: _____
___ _____

For Women Only

___ Atypical menstrual cycle (irregular or erratic, excessive flow, severe cramps, etc.)
___ Currently pregnant

For Men Only

___ Prostate trouble

3 Family History: Does anyone in your family have a history on the following: ____Yes ____ No
If yes mark (F) Father (M) Mother (S) Sibling (O) Other

___ Heart disease
___ Mental illness
___ Kidney disease
___ Autoimmune disorder
___ Arthritis
___ Seizure disorder
___ Cancer
___ Diabetes
___ Other: _____

4 Are you allergic to any medications? ___ Yes ___ No
If yes, please describe: _____

For office use only

X-Rays: Brought Taken Details: _____

Notes: _____

Completed By: _____ Date: _____