

Health History

Please indicate whether the following applies to the "T" Individual, "F" Family Member, or "B" Both.

<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Dislocated Joints	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Multiple Sclerosis
<input type="checkbox"/> Allergies	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Hip Pain	<input type="checkbox"/> Neck Pain
<input type="checkbox"/> Angina	<input type="checkbox"/> Duodenum Ulcer	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Anorexia	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Painful Urination
<input type="checkbox"/> Aortic Aneurysm	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Hyperthyroidism	<input type="checkbox"/> PMS
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Esophageal Cancer	<input type="checkbox"/> Hypothyroidism	<input type="checkbox"/> Polio
<input type="checkbox"/> Asthma	<input type="checkbox"/> Fainting	<input type="checkbox"/> Irregular Bowel Habits	<input type="checkbox"/> Profuse Menstrual
<input type="checkbox"/> Blood Disorder	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Irregular Menstrual	<input type="checkbox"/> Prostate Cancer
<input type="checkbox"/> Bone Cancer	<input type="checkbox"/> Gouty Arthritis	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Prostate Problems
<input type="checkbox"/> Brain Cancer	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Rapid Heart Rate
<input type="checkbox"/> Breast Soreness	<input type="checkbox"/> Headaches	<input type="checkbox"/> Knee Pain	<input type="checkbox"/> Rectum Cancer
<input type="checkbox"/> Breast Cancer	<input type="checkbox"/> Heart Attacks	<input type="checkbox"/> Leg Pain	<input type="checkbox"/> Scoliosis
<input type="checkbox"/> Bulemia	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Shoulder Pain
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Hepatitis A	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Sinus Trouble
<input type="checkbox"/> Colon Cancer	<input type="checkbox"/> Hepatitis B	<input type="checkbox"/> Lower Back Pain	<input type="checkbox"/> Spinal Disc Disorder
<input type="checkbox"/> Convulsions	<input type="checkbox"/> Hepatitis C	<input type="checkbox"/> Lung Cancer	<input type="checkbox"/> Stomach Cancer
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hernias	<input type="checkbox"/> Migrane	<input type="checkbox"/> Stroke

Other History _____

Patient Exercises: Moderately Occasionally Rarely Regularly Never

Patient Smokes: 2+ Packs per day 2 Packs per day 1 Pack per day 1/2 Pack per day or less
 Never Quit (how long ago) _____

Patient uses alcohol: Excessively Moderately Occasionally Rarely Never Quit

Medication the patient is currently taking: Analgesics Anti-inflammatory Asthma Birth Control
 Hypertension Muscle Relaxants Psychotropic Tranquilizers Vitamin Supplements
 Other _____ Other _____ Other _____ Other _____

Allergies: Animal Dander Dairy Products Dust Latex Penicillin Perfumes Pollen
 Seasonal Second Hand Smoke Sulfa Drugs No Known Allergies
 Other _____ Other _____ Other _____

Please list any pervious injuries and/or accidents with date _____

Past Surgical History (Indicate date, location, surgeon's name, type of surgery, and complications)

Past Hospitalizations (Indicate date, reason for hospitalization, and Complications) _____

History of Pregnancy _____

Treatment and Diagnostic Testing

<input type="checkbox"/> Plain X-Rays	Date _____	Location _____	Results _____
<input type="checkbox"/> CT Scan	Date _____	Location _____	Results _____
<input type="checkbox"/> MRI	Date _____	Location _____	Results _____
<input type="checkbox"/> EMG	Date _____	Location _____	Results _____
<input type="checkbox"/> Bone Scan	Date _____	Location _____	Results _____

Nerve Block Injection Trigger Point Injection EMG Needle Exam
 Botox Injection Epidural Injection IV
 Other _____
 Other _____
 Other _____

INITIAL _____ DATE _____