Patient Name: _____

Date: _____

Please circle any of the following conditions you presently have or have had in the past. If you circle any of the following, please give an approximate date when you were diagnosed and what was done for symptom relief. All conditions you may have at this time or in the past, which are not listed, please list in the space and describe as instructed.

Inflammatory, Cancer, Allergies, Arthritic, Hormonal, Metabolic, changes in eyesight, taste, smell, hearing, HIV/AIDS, Kidney, Stomach, Digestive, Pancreatic, Brain, Liver, Heart, Vascular, Respiratory, Surgeries, Depression, Fractures, Hypertension.

If you have had any physical traumatic events, such as car accidents, please list when they were and if you had symptoms as a result. _____

Please list all medications you currently are taking and the conditions you take them for. _____

Are you pregnant? _____

What is your job and what do you do physically in your job? _____

Do you exercise regularly? If so, what do you do, please be specific. _____

Do you take natural supplements regularly? If so, what do you take and how many milligrams of each per day? _____

What is the name and phone number of your primary care physician? _____

Have you ever been to a chiropractor before? If so when _____.