HISTORY UPDATE FORM

All questions contained in this questionnaire are strictly confidential and will become part of your chiropractic record.

Name *(First, MI, Last)*		**Date:**	**Chart:**	
Marital Status:	☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed			
Primary Doctor:		**Date of last physical exam:**		

PERSONAL HEALTH HISTORY

List any medical problems that other doctors have diagnosed: **Check here if none: ☐ None**

Please list all Surgeries and Hospitalizations (use back if necessary) **Check here if none: ☐ None**

Year	Reason	Outcome

Have you had any recent accident, injuries or traumas in the past year?	☐ No	☐ Yes: Use Back Of Sheet To Explain		
Have you ever been diagnosed with cancer? If yes, please list below with type, date, type of treatment.	☐	Yes	☐	No

Type: Date: Type of Treatment:

Type: Date: Type of Treatment:

Have you ever been diagnosed with the following:	☐ Diabetes ☐ Blood Pressure ☐ Stroke ☐ T.I.A. ☐ Asthma ☐ Osteoporosis ☐ None				
List your prescribed drugs and over-the-counter drugs, including vitamins and supplements (use back if necessary)					
1.	Dosage:	4.	Dosage:	7.	Dosage:
2.	Dosage:	5.	Dosage:	8.	Dosage:
3.	Dosage:	6.	Dosage:	9.	Dosage:

HEALTH HABITS

Exercise	☐ Sedentary (No exercise)								
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)								
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)								
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)								
Diet	Would you consider your diet healthy?					☐	Yes	☐	No
	Do you eat the recommended 10 servings of fruits and vegetables per day?					☐	Yes	☐	No
Fluids	How many 8-oz. glasses of water do you drink per day?	☐ None	☐ 1-2	☐ 3-4	☐ 5-6	☐ 7-8	☐	Over 8	
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola					
	# of cups/cans per day?								
Alcohol	Do you drink alcohol?					☐	Yes	☐	No
	How many drinks per week?								

Tobacco History	☐ Never Smoked	☐ Former Smoker *(please provide year only)* Start Date: End Date:	☐ Current Smoker Start Date:	☐ Cigarettes – pks./day
Medication Allergy	Do you have any allergic reactions to any medications?	☐ No	☐ Yes: *please list*	

OCCUPATION

Occupation	Type of work you perform:	☐ Full-Time ☐ Part-Time ☐ Disabled ☐ Retired ☐ Student ☐ None