



# HEALTH HISTORY FORM

## Patient Information

Full Name: \_\_\_\_\_ Date of Birth:

Address: \_\_\_\_\_

Gender:  Male  Female  Other Phone Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

## Physicians

Current PCP: \_\_\_\_\_  Date Last Physical: \_\_\_\_\_

Previous Chiropractor: \_\_\_\_\_  Date Last Visit: \_\_\_\_\_

### Allergies

None  Yes, list below:

\_\_\_\_\_  
\_\_\_\_\_

### Prescribed Meds / OTC

None  Yes, list below:

\_\_\_\_\_  
\_\_\_\_\_

## Your Personal Medical History (check all that apply):

- |  |  |  |                                   |
|--|--|--|-----------------------------------|
| <input type="checkbox"/> Anxiety                 | <input type="checkbox"/> Arthritis     | <input type="checkbox"/> Depression                  | <input type="checkbox"/> Migraine |
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Diabetes      | <input type="checkbox"/> High blood pressure         | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> History of Cancer _____ | <input type="checkbox"/> Heart disease | <input type="checkbox"/> No known medical conditions |                                   |
|  | <input type="checkbox"/> Cholesterol   |  |                                   |
- Other: \_\_\_\_\_

## Family Medical History (Check all that apply):

Family history of the following? (Check all that apply)

- Cancer  Diabetes  Heart disease  Mental health conditions
- Stroke  Other: \_\_\_\_\_

## Health Habits:

### Exercise:

- Sedentary (no exercise)
- Mild exercise
- Occasional-less 4x/wk
- Regular exercise -more than 4x/wk

### Diet / Nutrition

- Do you consider your diet healthy?
- Do you eat the recommended 10 servings fruits/veg day

# CHIROPRACTIC HISTORY FORM



Chiropractic Care &  
Wellness Center  
1563 Fall River Ave  
Seekonk, MA 02771

## Please list any past injuries, accidents or traumas: (car accident accidents, falls, sports played, work injuries)

- Sports Played: \_\_\_\_\_  
(list all contact sports played, any injuries playing sports)
- Car accidents: \_\_\_\_\_  
(List year and type of injury sustained/treatment)
- Previous Surgeries: \_\_\_\_\_
- Other: \_\_\_\_\_  
(falls, broken bones, traumas, injuries)

## Occupation:

Type of work you perform: \_\_\_\_\_

- Full-time    Part-time    Disabled    Retired    Student    None

## Reason For Your Visit Today:

Primary Reason:    Neck / Upper Back    Middle Back    Lower Back    Other: \_\_\_\_\_

Secondary Reason:    Neck / Upper Back    Middle Back    Lower Back    Other: \_\_\_\_\_

Tertiary Reason:    Neck / Upper Back    Middle Back    Lower Back    Other: \_\_\_\_\_

## Diagnostic Tests For This Issue:

None    X-rays:    MRI    CT Scan    Other: \_\_\_\_\_

Facility: \_\_\_\_\_

## Professional Treatment Consulted:

Chiropractor    MD / PCP    Physical Therapy    Orthopedist    Pain Management

Other: \_\_\_\_\_

Signature: By signing below, I confirm that the information provided is accurate to the best of my knowledge.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_