Medical Case History

HISTORY OF PRESENT ILLNESS

Chief Complaint: Purpose of this appointment:_____

Date symptoms appeared or accident happened:_____

Is this due to: Auto___ Work____ Other_____

Have you ever had the same or a similar condition? π Yes π No If yes, when and describe:_____

_____

Days lost from work:_____ Date of last physical examination:_____

PAST MEDICAL HISTORY

Have you ever been diagnosed as having or have suffered from? (Place a check mark by conditions that apply)

__Broken or Fractured Bones	__Osteoarthritis	__Eating Disorder	__Stroke
__Circulatory Problems	__Epilepsy	__Alcoholism	__Ulcers
__Rheumatoid Arthritis	__Pace Maker	__Drug Addiction	__Coughing Blood
__Seizures/Convulsions	__Strokes	__HIV Positive	__High/Low Blood Pressure
__A Congenital Disease	__Cancer	__Gall Bladder	
__Excessive Bleeding	__Ruptures	__Depression	

Have you had any major illnesses, injuries, falls, auto accidents or surgeries? Women, please include information about childbirth (include dates): _____

_____

Have you been treated for any health condition by a physician in the last year? π Yes π No

If yes, describe:_____

What medications or drugs are you taking?_____

_____

Please list any other health problems you have, no matter how insignificant they may be:_____

_____

Have you had chiropractic treatment previously? ___Yes___No If yes, for what_____

SOCIAL HISTORY:

Do you drink alcoholic beverages?___ If so, how much per week?_____
Do you use any tobacco products?_____Do you smoke?____ If so, packs per day: _____
Do you take vitamin supplements?_____ If so, please list:_____
Please indicate if you are interested in our clinical nutrition program and would like to be evaluated to see what vitamins and supplements may be right for you. _____Interested _____ Not Interested
Do you consume caffeine?____ If so, how much per day:_____
Do you exercise?_____ If yes, what is the frequency and type of exercise?_____
What are your hobbies?_____
What percentage of time during the day (at home or at your job away from home) do you spend:
lifting_____ sitting_____ bending_____working at a computer_____

FAMILY HISTORY:

Father: living___ deceased____ Current age if still living:_____
Cause of death and age at death if deceased:_____
Mother: living___ deceased____ Current age if still living:_____
Cause of death and age at death if deceased:_____
Do you have any family members who suffer from the same condition you do? If so, please list:_____

FAMILY DISEASES (check if applicable and indicate whether family member is **F**ather, **M**other, **S**ister, **B**rother):

Tuberculosis____	Cancer____	Mental Illness____
Diabetes ____	Asthma____	Heart Disease ____
Stroke ____	Kidney Disease____	Lung Disease____
Arthritis_____	Liver Disease ____	Other_____