

## Health Information:

Patient Name and Number: \_\_\_\_\_

### Past Treatments:

Have you ever been to a chiropractor?  Yes  No (If no, skip ahead.)

- How long has it been since your last adjustment? \_\_\_\_\_
- Did your previous chiropractor adjust your full spine (neck, mid-back & lower back) or focus on specific areas?  
\_\_\_\_\_
- Did your previous chiropractor use their hands or the activator (device) to adjust your spine? \_\_\_\_\_
- When was the last time you had x-rays of your spine? \_\_\_\_\_

### Past and Present Health Conditions:

Do you have any health issues that require medication or monitoring?  Yes  No (If no, skip ahead.)

- Please list any medications and what it is for: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Allergies:

Do you have any allergies?  Yes  No (If no, skip ahead.)

- Please list your allergies: \_\_\_\_\_  
\_\_\_\_\_

### Vitamins and Supplements:

Do you take vitamins or supplements?  Yes  No (If no, skip ahead.)

- Please list any vitamins or supplements you take: \_\_\_\_\_  
\_\_\_\_\_

### Surgeries:

Have you had any surgeries?  Yes  No (If no, skip ahead.)

- Please list: \_\_\_\_\_  
\_\_\_\_\_

### Family History:

Do your parents, siblings or children have any medical conditions that have to be medicated or monitored?

Yes  No (If no, skip ahead.)

- Please list: \_\_\_\_\_  
\_\_\_\_\_

### Social History:

Do you drink alcohol?  Yes  No (If no, skip ahead.)

Do you use tobacco products?  Yes  No (If no, skip ahead.)

What do you do for a living? \_\_\_\_\_