NAME ______________________________ **DATE** __________

______ **Ht** ______ **Wt** ______ **Temp** ______ **HR** ____/____ **BP**

PLEASE CIRCLE ANY THAT APPLY

PAST MEDICAL HISTORY:
PLEASE CIRCLE ANY THAT APPLY

Low Back Pain
Neck Pain
Head Ache/Migraines
Osteoarthritis
Gout
High Blood Pressure
Thyroid Disorder
Clicking Jaw
Irritable Bowel Syndrome
Constipation
Acid Reflux/Indigestion
Low Energy Levels
Sleeping Disorders
Painful Joints
Depression
Hormone Imbalance
Acne
Weight
Seasonal Allergies
Alcoholism
Alzheimer's
Rheumatoid Arthritis
Asthma
Anxiety
Atrial Fibrillation
Cancer_____________
Congestive Heart Failure
Coronary Artery Disease
Dementia
Diabetes
Dyspepsia
DVT
Pulmonary Embolism
Glaucoma
High Cholesterol
Multiple Sclerosis
Osteoporosis
Pneumonia
Seizure Disorder
Stroke
Parkinson's
Painful/Irregular Cycles
Other______________
No Significant History

SURGERIES:
PLEASE CIRCLE ANY THAT APPLY

Ankle/Hip
Shoulder
Appendectomy
Back Surgery
Carpal Tunnel
Cataract Extraction
Gall Bladder
Heart
Hernia
Lasix
Knee
Mastectomy
Thyroidectomy
Tonsillectomy
Tubal Ligation
Hysterectomy
Vasectomy
Other________________

Family History

Alcoholism
Alzheimer's
Depression
Anxiety
Diabetes
Glaucoma
Heart Disease
High Blood Pressure
Headaches
High Cholesterol
Multiple Sclerosis
Parkinson's
Seizures
Stroke
Cancer________________
Other_________________
No Significant History

SOCIAL HISTORY:
PLEASE CIRCLE ANY THAT APPLY

Marital Status- M / D / S / W
Regular Exercise- Y / N
Have You Ever Used Tobacco- Y / N
Current Use_______Pks/Day, Week
Recreational Drug Use- Y / N
DO YOU WANT TO QUIT- Y / N
Alcohol- None, Rare, Social
___/Day, Week, Month
Caffeine- Y / N
___/Day, Week
Occupation______________________
Sleep Habits- Well / Restless / Snore
Stressors________________________

Body System

Fatigue/Insomnia
Weight Changes
Chest Pain
Heart Pain
Depression
Menstrual Problems/Pregnant
Shortness of Breath
Urinary/Bowel Changes
Headaches
Other______________________

Chief Complaint:

____
____
____

Current Medications/Supplements:

____
____
____
____
____
____