

HEALTH HISTORY

Do you currently have any of the following? (please put a check in the appropriate space)

	YES	NO	NOT SURE
NECK PAIN			
MIDBACK PAIN			
LOWER BACK PAIN			
ARM/HAND PAIN OR TINGLING			
LEG/FOOT PAIN OR TINGLING			
HEADACHES			
RUPTURED OR HERNIATED DISC			
DIZZINESS OR BALANCE PROBLEMS			
BLACKOUTS OR FAINTING			
PROBLEMS WITH MEMORY OR CONCENTRATION			
PROBLEMS WITH BOWEL OR BLADDER FUNCTIONS			
CANCER OF ANY KIND			
TUBERCULOSIS			
RECENT FEVER			
RECENT UNEXPLAINED WEIGHT LOSS			
BURNING OR PAIN WHEN YOU URINATE			
CHEST PAIN OR PALPITATIONS			
HIGH BLOOD PRESSURE			
CHRONIC COUGH			
CARDIAC PACEMAKER			
SCOLIOSIS			
DIAGNOSED OSTEOARTHRITIS			
DIAGNOSED RHEUMATOID ARTHRITIS			
SHINGLES			
DIABETES			
VOMITING WITHIN THE PAST TWO WEEKS			
INTERNAL METAL SURGICAL CLIPS			
METAL IMPLANT OR APPLIANCE OF ANY KIND			
PAIN IN YOUR BIG TOE OR DIAGNOSED GOUT			
VISUAL PROBLEMS			
HEARING PROBLEMS			
SKIN PROBLEMS OTHER THAN ACNE			
DO YOU SMOKE? IF YES, HOW MANY PACKS/DAY: _____			
ARE YOU TAKING ASPIRIN OR ANTICOAGULANT MEDICINE			
(WOMEN) ARE YOU ON THE BIRTH CONTROL PILL			
(WOMEN) IS THERE ANY CHANCE THAT YOU ARE PREGNANT			
(MEN) PROSTATE PROBLEMS			

(FOR WOMEN) When did your last menstrual period start? DATE: _____

HEALTH HISTORY (page two)

Have you ever had any of the following? (please put a check in the appropriate space)

	YES	NO	NOT SURE
SURGERY ON YOUR NECK OR BACK			
HIP OR KNEE REPLACEMENT SURGERY			
CANCER OF ANY KIND			
STROKE OR MINI-STROKES			
HEART TROUBLE			
BROKEN BONES (LIST): _____			
HEPATITIS			
BLOOD IN YOUR STOOL			
THYROID PROBLEMS			
TUBERCULOSIS			
KIDNEY PROBLEMS			

Have any of your close relatives had any of the following conditions? (mark the appropriate space)

	MOTHER	FATHER	SISTER	BROTHER	CHILD
TUBERCULOSIS					
MIGRAINES					
CANCER					
SCOLIOSIS					
STROKE					
OSTEOARTHRITIS					
RHEUMATOID ARTHRITIS					

Please list any medications you are taking (over-the-counter medications included):

1. _____ 2. _____ 3. _____
 4. _____ 5. _____ 6. _____

List any surgeries not noted above: _____

By signing below, you agree to be responsible for payment for services provided at Priest Chiropractic, Inc. at the time such services are provided, unless prior arrangements have been made. You also acknowledge and accept that no guarantees are made or implied that your condition will improve, and could even possibly worsen despite the best efforts of the Physicians and Staff of Priest Chiropractic, Inc. If you have any questions, please speak with our Staff before beginning treatment.

NAME (PRINT) _____ SIGNATURE _____

TODAY'S DATE _____