

Health History

What treatment have you already received for your condition?

Medication

Surgery

Physical Therapy

Acupuncture

Chiropractic

None

Other _____

If so, Name and Address of doctor(s) who have treated you for your condition _____

Please mark **C** if a current condition, **P** if a past condition and leave blank if not applicable.

___ ADD/ADHD

___ Depression

___ Kidney Stone

___ Psychiatric Care

___ AIDS/HIV

___ Diabetes

___ Knee Pain

___ Rheumatic Fever

___ Anemia

___ Dizziness

___ Leg Pain

___ Scarlet Fever

___ Anorexia

___ Epilepsy

___ Liver Disease

___ Sciatica

___ Anxiety

___ Fainting

___ Low Back Pain

___ Seizures

___ Appendicitis

___ Fibromyalgia

___ Mid Back Pain

___ Shingles

___ Arm Pain

___ Gall Stones

___ Migraine Headaches

___ Shoulder Pain

___ Arthritis

___ Goiter

___ Miscarriage

___ Sinus Congestion

___ Asthma

___ Gout

___ Mononucleosis

___ STDs

___ Bronchitis

___ Headaches

___ Multiple Sclerosis

___ Stroke

___ Bulimia

___ Heart Disease

___ Mumps

___ Thyroid Problems

___ Cancer

___ Hepatitis

___ Neck Pain

___ Tonsillitis

___ Carpal Tunnel

___ Hernia

___ Night Sweats

___ Tuberculosis

___ Celiac Disease

___ Herniated Disc

___ Numbness or Tingling

___ Tumors/Growths

___ Chest Pain

___ Herpes

___ Osteoporosis

___ Ulcerative Colitis

___ Chicken Pox

___ High Cholesterol

___ Pacemaker

___ Ulcers

___ Chronic Fatigue

___ Hypertension

___ Parkinson's Disease

___ Upper Back

___ Cold Sores

___ Irritable Bowel Disease

___ Pinched Nerve

___ Urinary Tract Infection

___ Concussions

___ Infertility

___ Pneumonia

___ Vaginal Infection

___ Cough

___ Jaw pain

___ Polio

___ Whooping Cough

___ Crohn's Disease

___ Kidney Infections

___ Prostrate Problems

Others not listed above _____

Allergies:

Dust

Mold

Trees

Weeds

Grass

Animal

Perfume

Smoke

Foods (list on next page)

Others _____

Descriptions & Dates on the following:

Hospitalizations/Surgeries you have had _____

Recent Infections (Cold, Flu etc) _____

Falls/Injuries _____

Fracture/Dislocations _____

Medications _____

Vitamins/Supplements _____

Please list family history of any diseases or conditions _____