

COLLINS CHIROPRACTIC CLINIC

Medical History Information

Last Name:		<input type="checkbox"/> Mr.		<input type="checkbox"/> Miss		Marital status (circle one)	
First Name:		Middle:		<input type="checkbox"/> Mrs.		<input type="checkbox"/> Ms.	
Email:		DOB:		Age:		Sex:	
Address:		City:		State:		ZIP:	
Home Phone:		Cell Phone:		Social Security No.:			
Occupation:		Employer:		Employer phone:			
Emergency Contact/Relationship to Patient:				Emergency Contact Phone:			
Referred By:							
Medical Care Information							
Do You Have a Family Doctor?: <input type="checkbox"/> No <input type="checkbox"/> Yes, Name of Doctor: _____							
Address:		City:		State:		ZIP Code:	
Date of last Visit: / /		Date of last exam: / /					
Do You Have a Family Chiropractor?: <input type="checkbox"/> No <input type="checkbox"/> Yes, Name of Chiropractor: _____							
Address:		City:		State:		ZIP Code:	
Date of last Visit: / /		Date of last exam: / /					
Have you had surgeries in the last 5 Years: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Last Surgery Date: _____							
Reason for Surgery: _____							
History of Illness /Conditions:							
<input type="checkbox"/> AIDS	<input type="checkbox"/> Cancer	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Mental/ Emotional Difficulty	<input type="checkbox"/> Scoliosis	<input type="checkbox"/> Ulcer		
<input type="checkbox"/> Allergies	<input type="checkbox"/> Cirrhosis/hepatitis	<input type="checkbox"/> Heart Problem	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Sinus trouble			
<input type="checkbox"/> Anemia	<input type="checkbox"/> Diabetes	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Spinal Disc Disease			
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Dislocated joints	<input type="checkbox"/> HIV/ARC	<input type="checkbox"/> Polio	<input type="checkbox"/> STD'S			
<input type="checkbox"/> Asthma	<input type="checkbox"/> Diverticulitis	<input type="checkbox"/> Kidney trouble	<input type="checkbox"/> Prostate trouble	<input type="checkbox"/> Thyroid trouble			
<input type="checkbox"/> Bone fracture	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Tuberculosis			
Other: _____							
Family History of illness:							
<input type="checkbox"/> Anemia	<input type="checkbox"/> Cirrhosis/hepatitis	<input type="checkbox"/> Heart Problem	<input type="checkbox"/> Mental/ Emotional Difficulty	<input type="checkbox"/> Scoliosis	<input type="checkbox"/> Ulcer		
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Diabetes	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Spinal Disc Disease			
<input type="checkbox"/> Asthma	<input type="checkbox"/> Diverticulitis	<input type="checkbox"/> Kidney trouble	<input type="checkbox"/> Prostate trouble	<input type="checkbox"/> Thyroid trouble			
<input type="checkbox"/> Cancer	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Tuberculosis			
Other: _____							
Type of Cancer: <input type="checkbox"/> Breast <input type="checkbox"/> Lung <input type="checkbox"/> Other: _____							
Social History:							
Alcohol? <input type="checkbox"/> No <input type="checkbox"/> Yes Drinks per week? _____		Cigarettes? <input type="checkbox"/> No <input type="checkbox"/> Yes Packs per day? _____		Caffeine? <input type="checkbox"/> No <input type="checkbox"/> Yes Drinks per day? _____		Exercise? <input type="checkbox"/> No <input type="checkbox"/> Yes (circle one) Hours per week? _____ Light / Moderate / Strenuous	

MEDICATION LIST

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____

VITAMINS

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Signature: _____

Date: _____