PAST HEALTH HISTORY

PRIOR SIMILAR SYMPTOMS

Did you have any physical complaints just before the problem began? ☐ Yes ☐ No

If yes, please describe in detail : _____

PRIOR to this problem have you **EVER** had symptoms similar to what you're experiencing now? ☐ Yes ☐ No

If yes, please explain *(briefly include past falls, injuries, accidents, operations, etc.)* : _____

_____

Have you had any serious accidents which required medical care ? ☐ Yes ☐ No

Describe and give year : _____

Have you had any serious illnesses that required hospitalization ? ☐ Yes ☐ No

Describe and give year : _____

_____

Have you had any surgeries ? ☐ Yes ☐ No

If yes, list type of surgery and date : _____

_____

Have you had previous chiropractic care ? ☐ Yes ☐ No

If yes, list years and results : _____

_____

List broken bones and years : _____

_____

Drugs you now take : ☐ Nerve pills ☐ Pain killers ☐ Muscle relaxers ☐ "Pep" pills ☐ Tranquilizers
☐ Insulin ☐ Birth control pills ☐ Others _____

Age of mattress _____ ☐ Comfortable ☐ Uncomfortable

Are you wearing : ☐ Heel lifts ☐ Sole lifts ☐ Inner soles ☐ Arch supports

FAMILY HEALTH INFORMATION. (Many health problems are the result of hereditary spinal weaknesses; thus informatic about your family members will give us a better picture of your total health picture. Please include sisters, brothers and ar children.)

NAME	RELATION	AGE	HEALTH PROBLEMS OR CAUSE OF DEATH
	MOTHER		
	FATHER		