Element
Chiropractic

Health History

What Treatment have you already received for your condition? ___ Medication ___Surgery ___Physical Therapy ___Chiropractic ___Massage ___Other: _____

Date of Last: Physical Exam:_____ Spinal X-Ray_____ Blood Test_____

Spinal Exam _____ Chest X-Ray _____ Urine Test _____ Dental X-Ray _____

MRI, CT Scan, Bone Scan _____

Please **circle** any of the following conditions you HAD or currently HAVE:

AIDS/HIV	Alcoholism	Allergy Shots	Anemia	Anorexia
Appendicitis	Arthritis	Asthma	Bleeding Disorders	Breast Lump
Bronchitis	Bulimia	Cancer	Cataracts	Chem. Depend.
Chicken Pox	Diabetes	Emphysema	Epilepsy	Fractures
Glaucoma	Goiter	Gout	Heart Disease	Hepatitis
Hernia	Herniated Disk	Herpes	High Cholesterol	Hypertension
Kidney Disease	Liver Disease	Measles	Migraine Headaches	Miscarriage
Mononucleosis	Multiple Sclerosis	Mumps	Osteoporosis	Pacemaker
Parkinson's Disease	Pinched Nerve	Pneumonia	Polio	Poor Circulation
Prostate Problem	Psychiatric Care	Rheumatoid Arthritis	Rheumatic Fever	Scarlet Fever
Stroke	Suicide Attempt	Thyroid Problem	Tonsillitis	Tuberculosis
Tumors/Growths	Typhoid Fever	Ulcers	Vertigo	Whooping Cough

Other:_____

_____

Primary Care Provider: _____ **Phone:** _____

Address: _____

Signature: _____ Date:_____