



5734 West 13400 South Suite #200  
 Herriman, UT 84096  
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**HEALTH HISTORY**

Please check ALL of the health conditions below that apply to you currently or in the past.				Family History		Relationship:
				Mark ALL conditions that run in your family (Father, Mother, Sister, Brother)		
<input type="checkbox"/>	Osteoarthritis/Degenerative Joint Disease	<input type="checkbox"/>	Whiplash Injury <i>Date of injury:</i>	<input type="checkbox"/>	Cancer <i>Type:</i>	
<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	Anemia	
<input type="checkbox"/>	Diabetes <input type="checkbox"/> Type I <input type="checkbox"/> Type II Was your blood/lab work test for hemoglobin A1c > 9.0%? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure	<input type="checkbox"/>	Joint Pain ( <u>circle</u> location of pain): Shoulder, Elbow, Hip, Knee, Ankle Other: _____	<input type="checkbox"/>	Diabetes (check one) <input type="checkbox"/> Type I <input type="checkbox"/> Type II	
<input type="checkbox"/>	Anemia	<input type="checkbox"/>	Migraines	<input type="checkbox"/>	Heart Problems / Stroke	
<input type="checkbox"/>	Cancer/Tumor	<input type="checkbox"/>	Osteoporosis / Osteopenia	<input type="checkbox"/>	High Blood Pressure	
<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	Epilepsy / Seizures	<input type="checkbox"/>	Genetic Disorders	
<input type="checkbox"/>	Depression/ Anxiety	<input type="checkbox"/>	Fibromyalgia / Chronic Fatigue	<input type="checkbox"/>	Rheumatoid Arthritis	
<input type="checkbox"/>	Disc Herniation	<input type="checkbox"/>	Genetic Disorders	<input type="checkbox"/>	Other (List):	
<input type="checkbox"/>	High Blood Pressure / Hypertension	<input type="checkbox"/>	Please list any other medical conditions:			
<input type="checkbox"/>	Heart Disease / Stroke					

**FRACTURES (Broken Bones, Sprains, Strains, Major Trauma/Injury (List and Date:))**

\_\_\_\_\_

**SURGERIES and/or HOSPITALIZATIONS (List and Date:)**

\_\_\_\_\_

Have you had an X-ray or CT scan or MRI of your low back spine in the past 28 days?  Yes  No

List current prescription medications, including frequency and dosage if known. If there are NO current medications, check here

Name of prescription medication	Dosage/Start date	4.	
1.		5.	
2.		6.	
3.		7.	

List any know allergies you have had to prescription medications. If NO medication allergies are known, check here

1. \_\_\_\_\_ 2. \_\_\_\_\_

**SOCIAL HISTORY**

Height	Ft.	In.	Weight:	Lbs.,
Do you exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No Times per week? Intensity? <input type="checkbox"/> Light <input type="checkbox"/> Moderate <input type="checkbox"/> Strenuous Type?:				
Do you currently smoke tobacco of any kind? <input type="checkbox"/> Yes <input type="checkbox"/> Former smoker <input type="checkbox"/> Never been a smoker				
If "Yes", how often do you smoke: <input type="checkbox"/> Current every day smoker <input type="checkbox"/> Current sometimes smoker <b>(Circle) level below ↓:</b>				
If "Yes", what is your level of interest in quitting smoking? (0 = NO interest, 10=very interested) 0 1 2 3 4 5 6 7 8 9 10				
Do you drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No How many drinks per week? For how many years?				
Do you drink caffeine? <input type="checkbox"/> Yes <input type="checkbox"/> No How many drinks per day? What type? <input type="checkbox"/> Coffee <input type="checkbox"/> Tea <input type="checkbox"/> Soft Drinks <input type="checkbox"/> Energy Drinks				
Do you take pain killers? <input type="checkbox"/> Yes <input type="checkbox"/> No How often? <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Rarely What type? <input type="checkbox"/> Aspirin <input type="checkbox"/> Ibuprofen <input type="checkbox"/> Tylenol <input type="checkbox"/> Other _____				
What do your work duties include? <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Light Labor <input type="checkbox"/> Heavy Labor <input type="checkbox"/> Other:				
Please describe your overall health right now? <input type="checkbox"/> Excellent <input type="checkbox"/> Very Good <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor				
What is your current stress level? <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> High				
Have you seen a chiropractor in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No				
What are your hobbies?				

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_