Bonsall Chiropractic Registration and History

6 Health History

What treatment have you already received for your condition?: ☐ Medications ☐ Surgery ☐ Physical Therapy ☐ Chiropractic Services ☐ None ☐ Other _____

Name and address of other doctor(s) who have treated you for your condition: _____

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 _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV ☐ Yes ☐ No	Emphysema ☐ Yes ☐ No	Miscarriage ☐ Yes ☐ No	Scarlet Fever ☐ Yes ☐ No
Alcoholism ☐ Yes ☐ No	Epilepsy ☐ Yes ☐ No	Mononucleosis ☐ Yes ☐ No	Stroke ☐ Yes ☐ No
Allergy Shots ☐ Yes ☐ No	Fractures ☐ Yes ☐ No	Multiple Sclerpsos ☐ Yes ☐ No	Suicide Attempt ☐ Yes ☐ No
Anemia ☐ Yes ☐ No	Glaucoma ☐ Yes ☐ No		Tonsillitis ☐ Yes ☐ No
Anorexia ☐ Yes ☐ No	Goiter ☐ Yes ☐ No	Mumps ☐ Yes ☐ No	Thyroid Problems ☐ Yes ☐ No
Appendicitis ☐ Yes ☐ No	Gonorrhea ☐ Yes ☐ No	Osteoporosis ☐ Yes ☐ No	
Arthritis ☐ Yes ☐ No	Gout ☐ Yes ☐ No	Pacemaker ☐ Yes ☐ No	Tuberculosis ☐ Yes ☐ No
Asthma ☐ Yes ☐ No	Heart Disease ☐ Yes ☐ No	Parkinson's Disease ☐ Yes ☐ No	Tumors, Growths ☐ Yes ☐ No
Bleeding Disorders ☐ Yes ☐ No	Hepatitis Disorders ☐ Yes ☐ No	Pinched Nerve ☐ Yes ☐ No	Typhoid Fever ☐ Yes ☐ No
Breast Lump ☐ Yes ☐ No	Hernia ☐ Yes ☐ No	Pneumonia ☐ Yes ☐ No	Ulcers ☐ Yes ☐ No
Bronchitis ☐ Yes ☐ No	Herniated Disk ☐ Yes ☐ No	Polio ☐ Yes ☐ No	Vaginal Infections ☐ Yes ☐ No
Bulimia ☐ Yes ☐ No	Herpes ☐ Yes ☐ No	Prostate Problem ☐ Yes ☐ No	
Cancer ☐ Yes ☐ No	High Cholesterol ☐ Yes ☐ No	Prosthesis ☐ Yes ☐ No	Venereal Disease ☐ Yes ☐ No
Cataracts ☐ Yes ☐ No	Kidney Disease ☐ Yes ☐ No	Psychiatric Care ☐ Yes ☐ No	Whooping Cough ☐ Yes ☐ No
Chemical Dependency ☐ Yes ☐ No	Measles ☐ Yes ☐ No	Rheumatoid Arthritis ☐ Yes ☐ No	
Chicken Pox ☐ Yes ☐ No	Liver Disease ☐ Yes ☐ No		Other: _____
Diabetes ☐ Yes ☐ No	Migraine Headaches ☐ Yes ☐ No	Rheumatic Fever ☐ Yes ☐ No	

EXERCISE
- ☐ None
- ☐ Moderate
- ☐ Daily
- ☐ Heavy

WORK ACTIVITY
- ☐ Sitting
- ☐ Standing
- ☐ Light Labor
- ☐ Heavy Labor

HABITS
- ☐ Smoking → Packs/Day _____
- ☐ Alcohol → Drinks/Week _____
- ☐ Coffee/Caffeine Drinks → Cups/Day _____
- ☐ High Stress Level → Reason _____
- ☐ Other: _____

Are you pregnant?: ☐ Yes ☐ No Due Date: _____

Injuries/Surgeries you have had:	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

7 Medications | Allergies | Vitamins/Herbs/Minerals

Pharmacy Name: _____

Pharmacy Phone: _____