

# Pure Chiropractic Center

## Medical History Information

How did you hear about us? \_\_\_\_\_

What language do you prefer communication from our office:  English  Spanish  Russian

Last Name:		Middle:		<input type="checkbox"/> Mr.	<input type="checkbox"/> Miss	Marital status (circle one) Single / Mar / Div / Sep / Widow	
First Name:				<input type="checkbox"/> Mrs.	<input type="checkbox"/> Ms.		
Email:		Height:	Weight:	Birth date:		Age:	Sex:
Address:			City:		State:		
ZIP Code:		Social Security No.:		Home Phone:			
Occupation:		Employer:			Employer phone:		
<b>Medical Care Information</b>							
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:							
<b>Present illness /Conditions:</b>							
<input type="checkbox"/> AIDS	<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart Problem	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Spinal Disc Disease			
<input type="checkbox"/> Allergies	<input type="checkbox"/> Cirrhosis/hepatitis	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Thyroid trouble	<input type="checkbox"/> Epilepsy		
<input type="checkbox"/> Anemia	<input type="checkbox"/> Diabetes	<input type="checkbox"/> HIV/ARC	<input type="checkbox"/> Prostate trouble	<input type="checkbox"/> Tuberculosis		<input type="checkbox"/>	
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Dislocated joints	<input type="checkbox"/> Kidney trouble	<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Ulcer		<input type="checkbox"/>	
<input type="checkbox"/> Asthma	<input type="checkbox"/> Diverticulitis	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Scoliosis	<input type="checkbox"/> Polio		<input type="checkbox"/>	
<input type="checkbox"/> Bone fracture	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Mental/ Emotional Difficulty	<input type="checkbox"/> Sinus trouble	<input type="checkbox"/> STD'S		<input type="checkbox"/>	
Other:							
<b>Family History of illness:</b>							
<input type="checkbox"/> AIDS	<input type="checkbox"/> Cancer	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Spinal Disc Disease	<input type="checkbox"/> STD'S			
<input type="checkbox"/> Allergies	<input type="checkbox"/> Bone fracture	<input type="checkbox"/> Heart Problem	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Sinus trouble	<input type="checkbox"/> Ulcer		
<input type="checkbox"/> Anemia	<input type="checkbox"/> Cirrhosis/hepatitis	<input type="checkbox"/> HIV/ARC	<input type="checkbox"/> Mental/ Emotional Difficulty	<input type="checkbox"/> Epilepsy		<input type="checkbox"/> Polio	
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Diabetes	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Prostate trouble	<input type="checkbox"/> Thyroid trouble	<input type="checkbox"/> Scoliosis		
<input type="checkbox"/> Asthma	<input type="checkbox"/> Dislocated joints	<input type="checkbox"/> Kidney trouble	<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Tuberculosis		<input type="checkbox"/> Diverticulitis	
Other:							
<b>Type of Cancer:</b>		<input type="checkbox"/> Breast		<input type="checkbox"/> Lung		<input type="checkbox"/> Other:	
<b>Social History:</b>							
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) Light / Moderate / Strenuous	

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.