

KONICKI SCHUMACHER CHIROPRACTIC CLINIC

We need your complete health report before we can be responsible for your case.
This is a medical history. We do not claim to treat or cure all your reported conditions.

Name: _____

Date: _____

Have you been to a chiropractor (when and why)? _____

List your medications and reason for taking them: _____

Had any surgeries (what operations and when)? _____

Had a major fall/accident/injury? _____

Had any broken bones? _____

Any joint pain (other than main complaint)? _____

Numbness/tingling (where)? _____

Arthritis (where?) _____

TMJ pain? _____

Heart condition? _____

Blood pressure problems? _____

Circulation problems? _____

Had any strokes/TIA's? _____

Eyes, Ears, Nose, Throat problems? _____

Respiratory/Lung problems? _____

Stomach/Intestines/Bowel Problems? _____

Kidney/Bladder Problems? _____

Diabetes? _____ Depression? _____

Headaches? _____ Pain w/menstruation, cramps? _____

Dizziness? _____ Thyroid Condition? _____

Are you pregnant? _____ No. of Children _____

HABITS

None Light Mod. Heavy

Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Soft Drinks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sugar & Products	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dairy Foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Y N Have you ever had cancer?

Y N Are you losing weight without trying?

Y N Does pain wake you up at night?

Y N Have you had a change in bowel or bladder habits?

Y N Have you had a sore that doesn't heal?

Y N Have you recently had any unusual bleeding or discharge?

Y N Do you have a thickening/lump in the breast or elsewhere?

Y N Do you have indigestion or difficulty swallowing?

Y N Have you had an obvious change in a wart or mole?

Y N Do you have a nagging cough or hoarseness?

Anything else the doctor should know about you?

