HEALTH HISTORY

Name of PCP(Primary Care Physician):_____ **PCP's Phone #:**_____

Date of Last: Physical Exam:_____ **Spinal X-ray:**_____

Are you Right or Left Handed? □ Right □ Left Do you wear heel lifts or orthotics? □ Yes □ No

Injuries and/or Surgeries	**Describe**	**Date**
Auto Accidents:		
Falls/Strains/Sprains:		
Broken Bones:		
Surgeries/Hospitalizations:		

Please List ALL:

Medications:_____

Supplements:_____

Allergies:_____

HABITS: Water: Glasses per day _____ Caffeine:Cups per Day_____ Alcohol Drinks:_____ per Day / Week

Exercise: □ Light □ Moderate □ Heavy Work Activities: □ Sitting □ Standing □ Light Labor □ Heavy Labor

Smoke: □ Cigarettes: Packs per Day_____ □ Cigars: per day_____ Constant High Stress Levels: □Yes □No

Place a mark on "Yes" to indicate if you have had any of the following:

AIDS/HIV	□Yes	Fibromyalgia	□Yes	Menstrual Problems	□Yes	Rheumatoid Arthritis	□Yes
Alcoholism	□Yes	Fractures	□Yes	Migraines	□Yes	Scarlett Fever	□Yes
Allergy Shots	□Yes	Glaucoma	□Yes	Miscarriage	□Yes	Scoliosis	□Yes
Anemia	□Yes	Gonorrhea	□Yes	Mononucleosis	□Yes	Spinal Stenosis	□Yes
Anorexia	□Yes	Gout	□Yes	M. S.	□Yes	Stroke	□Yes
Appendicitis	□Yes	Heart Disease	□Yes	Mumps	□Yes	Thyroid Problem	□Yes
Appendectomy	□Yes	Heart Attack	□Yes	Overweight	□Yes	Tonsilitis	□Yes
Arthritis	□Yes	Hepatitis	□Yes	Osteopenia	□Yes	Tuberculosis	□Yes
Asthma	□Yes	Hernia	□Yes	Osteoporosis	□Yes	Tumors/Growths	□Yes
Breast Lumps	□Yes	Herniated Disk	□Yes	Pacemaker	□Yes	Scoliosis	□Yes
Bronchitis	□Yes	Herpes/Shingles	□Yes	Parkinson's	□Yes	Ulcers	□Yes
Cancer	□Yes	High Blood Pressure (B/P)	□Yes	Pinched Nerve	□Yes	Urinary Tract Infection	□Yes
Chemical Dependency	□Yes	Low B/P	□Yes	Pleurisy	□Yes	Vaginal Infections	□Yes
Chicken Pox	□Yes	High-Cholesterol	□Yes	Pneumonia	□Yes	Valley Fever	□Yes
Depression	□Yes	Kidney Disease	□Yes	Polio	□Yes	Venereal Disease	□Yes
Diabetes	□Yes	Kidney Stones	□Yes	Prostate Problem	□Yes	Whooping Cough	□Yes
Ear Infections	□Yes	Liver Disease	□Yes	Prosthesis	□Yes	Other _____	
Emphysema	□Yes	Lupus	□Yes	Psychiatric Care	□Yes		
Epilepsy/seizures	□Yes	Measles	□Yes	Rheumatic Fever	□Yes		

Females: Pregnancies(How many?)_____How many children?_____Are you pregnant now? □Yes □No Due date:_____

*I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I further understand and agree that I am personally responsible for payment in full of all services and supplies rendered to me by this office. I agree that any outstanding balance for services rendered to me by Superior Chiropractic Centers, is subject to the interest rate of 24% A.P.R. and will be charged to my balance each month from the date of the last visit and will be paid in addition to all unpaid charges. Returned checks are subject to a $30.00 processing fee. In the event that my account balance is referred for collection, I agree to pay collection fees up to 50% on the balance owing. If legal action is deemed necessary, I agree to pay reasonable attorney's fees and all court costs in addition to the above costs. I have read and fully understand the above information. With my signature, I agree that all statements in the aforementioned are true and accurate and I will abide by these terms set forth.

Patient and/or Guardian Signature_____ **Date**_____

Witness Name_____ **Date**_____

DR. INITIALS_____ DATE_____