NAME_____DATE_____

(Please fill out completely)

HAVE YOU EVER HAD:	YES	NO
1. Heart Disease or Heart Attack……	○	◉
2. Lung Disease……...	○	○
3. Stomach or Bowel Problems……..	○	○
4. Circulation Problems……..	○	○
5. Diabetes……	○	○
6. Cancer……..	○	○
7. Thyroid Problems……	○	○
8. High Blood Pressure……	○	○
9. HIV……...	○	○
10. Are you taking any Herbal medications Herbal teas?	○	○
11. Are you taking any Bone medication?	○	○

IF YES, PLEASE
EXPAIN_____

_____

CHIEF COMPLAINT: REASON FOR TODAY'S VISIT? _____

_____

DATE OF ONSET OF PAIN OR PROBLEM: _____

PAST SURGERIES: _____

CURRRENT MEDICATIONS: _____

_____

ALLERGIC TO MEDICATIONS: _____

SOCIAL HISTORY:

OCCUPATION _____
HEIGHT_____ WEIGHT _____
SMOKE _____ HOW MUCH? _____
ALCOHOL _____ HOW MUCH? _____