Health History Form (revised 9/30/09)

Name ____ Date ____________

Age ____ Birthdate ____________ □ Female □ Male Home Phone _______________________

Address: ____
Street City State Zip

Employer____ Occupation ________________________

Work Phone ______________________________ Cell Phone _________________________________

E-mail Address: ____

Do you have medical insurance? □ yes □ no Ins. Company_________________________________

Spouse/Partner Name ______________________________ Spouse/Partner Phone _________________

Marital Status: □ Single □ Married □ Separated □ Divorced □ Widowed # of children _______

Person to notify in an emergency ____
Name Relationship Phone Number

Who referred you to Dr. Frasure? ____

Have you ever been to a chiropractor before? □ Yes □ No If yes, who? _________________________

If yes, when was your last treatment with that doctor? _______________________________________

List the main reason for today's visit. When did this start and how?

____

____

____

____

Have you ever had this condition before? □ Yes □ No If so, when? ____________________________

List any secondary complaints:

____

____

____

List all prescription medications that you are currently taking on a regular basis:

____

____

Do you have any allergies or reactions to medications? □ Yes □ No If so, please list: _____________

____

Please check if you have any of the following conditions:
Heart disease _____ High blood pressure _____ High cholesterol _____ Thyroid disease ______
Diabetes _____ Cancer _____ Osteoporosis _____ Osteopenia _____ Enlarged Prostate ______
Other ____

Have you ever been knocked unconscious? □ Yes □ No If so, how and when? ___________________

____

Please list any accidents (including Auto accidents) resulting in injuries:

Date	What happened/type of injury

Please list all prior surgeries:

Date	Type of surgery/part of the body

List any sprains and/or fractures:

Date	What part of the body?

Cigarettes: □ Never □ Quit date ____________ Current smoker: packs/day ____ # of years __________
Other tobacco: □ Pipe □ Cigar □ Snuff □ Chew

Do you drink alcohol? □ yes □ no What kind? _________________ # of drinks per week? __________

Do you use any recreational drugs: □ yes □ no If so, what? ___________________________________

Caffeine Intake: □ None □ Coffee □Tea □ Soda □ Energy drinks How many cups a day? _________

How do you rate your diet: □ Good □ Fair □ Poor Are you □ right or □ left handed?

Do you exercise regularly? □ yes □ no What kind of exercise? _________________________________

Family History:

Mother: □ living in: □ Good □ Fair □ Poor health or □ deceased - due to: :______________________

Father: □ living in: □ Good □ Fair □ Poor health or □ deceased - due to: :______________________

Do you have siblings? □ Yes □ No How many Brothers? ___________ Sisters? ___________

Indicate if your mother (M), father (F), brothers (B) or sisters (S) ever had any of the following conditions?

	Cancer		Heart Disease		High Cholesterol
	High Blood Pressure		Stroke		Other: ___________________________

____ ____________________

Patient/Legal Guardian Signature Date