

KANADY

CHIROPRACTIC CENTER

Patient Name: _____ Date: _____

“HEALTH HISTORY”

Purpose of this appointment:

On the Job Injury Personal Injury Auto Collision Other

Other Doctors seen for this condition _____

Diagnosis _____ Treatment _____

Length of Care _____ Results _____

Do you have any of these symptoms?

Dizziness _____ Arthritis _____ Nervousness _____

Backaches _____ Headaches _____ Sinus Trouble _____

Heart Trouble _____ Asthma _____ Anemia _____

Diabetes _____ High blood pressure _____ Digestive disorder _____

Tuberculosis _____ Rheumatic fever _____ Other _____

Have you been treated for any other health condition by a Chiropractor or Medical Physician in the last year? Yes No

Describe _____

Date of last Physical Examination _____

Fractures or Breaks: Bone(s) _____

Surgery: Type(s) _____

Major Accidents or Injuries: What _____

Current Drugs or Medication _____

Unusual Disease or Condition _____ Diagnosis Date _____

Do you presently have any health condition that we should be aware of? No Yes

Have any of your blood relatives (parents/siblings) had any of the following conditions:

Diabetes Mellitus High Blood Pressure Arteriosclerosis Heart Disease Gout Degenerative Disc Disease

Arthritis Abnormalities and Deformities of the Spine Curvature or Scoliosis of the Spine Cancer

DAILY HABITS

Do you exercise daily? None Moderate Heavy

What vitamins and/or supplements do you currently take? _____

Do you smoke? No Yes How much per day? _____