3 Fold Healing Chiropractic History Form

Please complete every section as fully as you can. Leave blank anything that does not apply.

1. PATIENT INFORMATION

Full name	
Today's date (MM/DD/YYYY)	
Birthday (MM/DD/YYYY)	
Age	
Blood type	Select...
Gender born with	Select...
Home address (street, city, state, ZIP)	
State and town you grew up in	
Who referred you?	

2. REASON FOR THIS VISIT

Main reason for this appointment	
Present condition (what, where, since when)	
Current pain level (1 mild - 10 worst)	Select...
Date of last visit with a chiropractor	

3. MEDICAL BACKGROUND

Present medications (name, dose, how often)	
Surgeries in the last 10 years (type and year)	
Vaccines (which, and year of most recent)	

4. PAST AND PRESENT MEDICAL HISTORY CHECKLIST

Check every condition you have had in the past or have now.

Musculoskeletal

- ☐ Neck pain or whiplash
- ☐ Back pain or sciatica
- ☐ Herniated or bulging disc
- ☐ Arthritis or osteoporosis
- ☐ Scoliosis
- ☐ Fractures or dislocations
- ☐ Joint pain (shoulder, hip, knee, other)

Neurological

- ☐ Headaches or migraines
- ☐ Dizziness or vertigo
- ☐ Numbness or tingling
- ☐ Seizures
- ☐ Stroke

Heart, lungs and circulation

- ☐ High blood pressure
- ☐ Heart disease or heart attack
- ☐ Blood clots
- ☐ Asthma or breathing problems

General health

- ☐ Diabetes
- ☐ Cancer
- ☐ Thyroid disorder
- ☐ Kidney or liver disease
- ☐ Digestive problems
- ☐ Depression or anxiety
- ☐ Sleep problems
- ☐ Allergies
- ☐ Currently or possibly pregnant
- ☐ Car, work or sports injury

If cancer, type:

If allergies, to what:

Notes on any item checked