

Duxbury Sports Chiropractic and Fitness

Medical History Information

Last Name:		Marital status (circle one)		
First Name:		Single / Mar / Div / Sep / Widow		
Middle:				
Email:	Birth date:	Age:	Sex:	
Address:	City:	State:		
ZIP Code:	Cell Phone:	Home Phone:		
Occupation:	Employer:			
Medical Care Information				
Do You Have a Family Doctor?: <input type="checkbox"/> No <input type="checkbox"/> Yes, Name of Doctor:				
Address:		City:	State: ZIP Code:	
Date of last Visit: / /		Date of last exam: / /		
Do You Have a Family Chiropractor?: <input type="checkbox"/> No <input type="checkbox"/> Yes, Name of Chiropractor:				
Address:		City:	State: ZIP Code:	
Date of last Visit: / /		Date of last exam: / /		
Have you had surgeries in the last 5 Years: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Last Surgery Date:				
Reason for Surgery:				
Present illness /Conditions:				
<input type="checkbox"/> AIDS	<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart Problem	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Spinal Disc Disease
<input type="checkbox"/> Allergies	<input type="checkbox"/> Cirrhosis/hepatitis	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Thyroid trouble <input type="checkbox"/> Epilepsy
<input type="checkbox"/> Anemia	<input type="checkbox"/> Diabetes	<input type="checkbox"/> HIV/ARC	<input type="checkbox"/> Prostate trouble	<input type="checkbox"/> Tuberculosis <input type="checkbox"/>
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Dislocated joints	<input type="checkbox"/> Kidney trouble	<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Ulcer <input type="checkbox"/>
<input type="checkbox"/> Asthma	<input type="checkbox"/> Diverticulitis	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Scoliosis	<input type="checkbox"/> Polio <input type="checkbox"/>
<input type="checkbox"/> Bone fracture	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Mental/ Emotional Difficulty	<input type="checkbox"/> Sinus trouble	<input type="checkbox"/> STD'S <input type="checkbox"/>
Other:				
Family History of illness:				
<input type="checkbox"/> AIDS	<input type="checkbox"/> Cancer	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Spinal Disc Disease	<input type="checkbox"/> STD'S
<input type="checkbox"/> Allergies	<input type="checkbox"/> Bone fracture	<input type="checkbox"/> Heart Problem	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Sinus trouble <input type="checkbox"/> Ulcer
<input type="checkbox"/> Anemia	<input type="checkbox"/> Cirrhosis/hepatitis	<input type="checkbox"/> HIV/ARC	<input type="checkbox"/> Mental/ Emotional Difficulty	<input type="checkbox"/> Epilepsy <input type="checkbox"/> Polio
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Diabetes	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Prostate trouble	<input type="checkbox"/> Thyroid trouble <input type="checkbox"/> Scoliosis
<input type="checkbox"/> Asthma	<input type="checkbox"/> Dislocated joints	<input type="checkbox"/> Kidney trouble	<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Tuberculosis <input type="checkbox"/> Diverticulitis
Other:				
Type of Cancer: <input type="checkbox"/> Breast <input type="checkbox"/> Lung <input type="checkbox"/> Other:				
Social History:				
Alcohol? <input type="checkbox"/> No <input type="checkbox"/> Yes Drinks per week?	Cigarettes? <input type="checkbox"/> No <input type="checkbox"/> Yes Packs per day?	Caffeine? <input type="checkbox"/> No <input type="checkbox"/> Yes Drinks per day?	Exercise? <input type="checkbox"/> No <input type="checkbox"/> Yes (circle one) Light / Moderate / Strenuous	
Misc.:				

How did you hear about us? _____

Signature: _____

Date: _____

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.