McKINNEY FAMILY CHIROPRACTIC
CONFIDENTIAL HEALTH HISTORY

Date: _____

Name:_____Sex_____Marital Status_____DOB_____
First Name MI Last Name M F M S D W MM/DD/YY

Address:_____City:_____Zip:_____SS#_____

Phone#:_____Cell#:_____Who referred you to this office:_____

Business Phone_____Employer:_____Occupation:_____
Spouse's Name_____Spouse's SS#_____Spouse's Employer_____

Insurance Policy Name_____Insurance Policy #_____
Policyholder's Name_____Policyholder's Date Of Birth_____
Policyholder's Employer_____

Please list anyone we can speak to about your condition/treatment:_____
Do you use: Alcohol_____ Tobacco _____ Coffee_____ Height: _____ Weight: _____
Do you take vitamins?_____ If yes, what do you take? _____

Please describe the principal health problem for which you came to this office _____
_____

Date you first noticed symptoms _____

List any diagnosis and/or treatment given _____

Have you lost any days of work for this condition____Please explain_____

List any relatives that have had similar condition _____

Have you or any relative received chiropractic treatment previously?_____Please explain _____
_____

Have you been treated for any health condition by a physician in the past year?____Please explain____
_____

Are you currently taking any medication?____ If yes, please list _____

List any surgery or unusual diseases you have had (list dates) _____
_____

Have you or anyone in your family had a stroke, TIA, or stroke like symptoms?_____

Have you had rapid weight gain or loss in the past 6 months?_____

PLEASE FILL OUT THE BACK OF THIS FORM

NAME _____ **DATE**_____

PLACE AN "X" ON ANY PROBLEMS YOU ARE CURRENTLY HAVING

MUSCULO-SKELETAL

____low back
____Pain between shoulders
____Neck Pain
____Arm Pain
____Leg Pain
____Painful joints
____Muscle Pain

GENITO-URINARY SYSTEM

____ Bladder trouble

FEMALE
____ Vaginal problems
____Breast pain/lumps

ARE YOU PREGNANT?
____Yes _____No

GASTRO-INTESTINAL SYSTEM

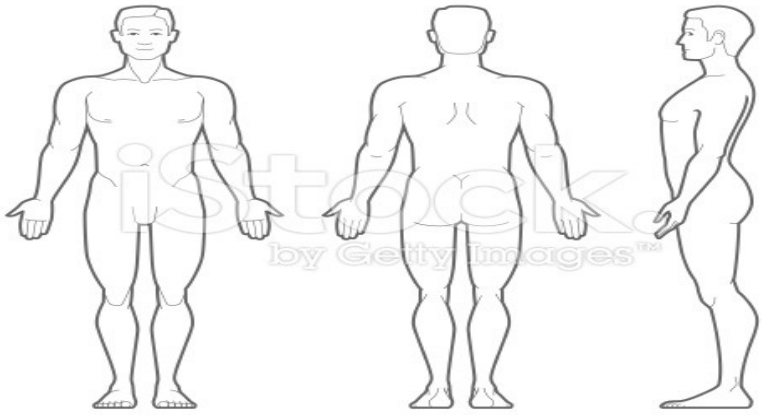
_____ Poor / excessive appetite
_____Excessive hunger
_____Vomiting food/blood
_____Diarrhea/constipation
_____Hemorrhoids
_____Liver Trouble
_____Gallbladder trouble

NERVOUS SYSTEM

____Numbness ____Headaches
____Dizziness ____Confusion
____Fainting ____Depression

CARDIO-VASCULAR SYSTEM

____Pacemaker ____Coughing blood
____Chest Pain ____Lung Problems
____Difficult blood ____Heart Problems



In case of emergency, please notify _____Telephone _____

I understand that this office wil bill my insurance as a courtesy to me. I give permission to the doctor to release information requested by the insurance company concerning my health history, examinations and treatment. I hereby authorize and direct my insurance benefits to be paid directly to the doctor. I understand that I am responsible for all charges incurred in this office.

Though Chiropractic adjustment and treatments are usually beneficial and seldom cause any problem, I understand and am informed that there are some risks to treatment. Risks include, but are not limited to, fractures, disc injuries, strokes, dislocations, and sprains.

I verify that the above information which I have provided is correct. I also verify that I have read the above information, and that I am agreeable with it's contents. I also agree that no results are guaranteed.

_____Patient Signature