C. REVIEW OF SYSTEMS (CONTINUED)

2. What Hobbies Do You Participate In?

List Hobbies:	Occasionally	Frequently	Constantly
1. _____	○	○	○
2. _____	○	○	○
3. _____	○	○	○

3. What Are Your Habits?

Smoking	Packs/Day: Never ○	<1 ○	1-2 ○	2-3 ○	3-4 ○	5+ ○
Alcohol	Drinks/Day: Never ○	<1 ○	1-2 ○	2-3 ○	3-4 ○	5+ ○
Caffeinated Drinks	Cups-Glasses/Day: Never ○	<1 ○	1-2 ○	2-3 ○	3-4 ○	5+ ○
Exercise	Days/Week: Never ○	<1 ○	1-2 ○	3-4 ○	5-6 ○	7 ○

Drug/Substance Abuse — Never ○ Yes ○ If Yes, Discuss With Doctor

D. MEDICAL HISTORY

1. Health Care

a. Have You Been To A Chiropractor ..... Yes ○ No ○

b. Do You Have A Family Physician ..... Yes ○ No ○

Date Of Last Physical Exam _____

Physician's Name & Address _____

c. Have You Been Hospitalized In The Past Five Years ..... Yes ○ No ○

Date & Reason For Hospitalization _____

d. Have You Had Surgery In The Past Five Years ..... Yes ○ No ○

Date & Reason For Surgery _____

e. Have You Had A Serious Accident In The Past Five Years ..... Yes ○ No ○

○Auto ○Work ○Home ○Other

List Date & Describe Injury _____

f. Do You Have Any Drug Allergies ..... Yes ○ No ○

List Drugs _____

g. Are You Currently Taking Any Medication . Yes ○ No ○

○Anti-inflammatory (Aspirin, Motrin, etc.)
○Muscle Relaxants ○Pain Medication/Analgesic
○Tranquilizers ○Antibiotics
○Blood Pressure Pills ○Other
○Birth Control Pills

For What Condition/s Are You Taking Medication?

h. WOMEN ONLY:

To Your Knowledge Are You Pregnant .... Yes ○ No ○
Have Your Past Pregnancies Been Normal . Yes ○ No ○
Are You Seeing An OB-GYN Regularly .... Yes ○ No ○

Date Of Last Exam _____

Physician's Name & Address _____

2. If you now have or you have had one of the following illnesses, please fill in EITHER bubble NH or bubble HH.

○ ***No Previous Conditions/Illnesses***

Now Have	Have Had		Now Have	Have Had	
NH ○	HH ○	Arthritis	NH ○	HH ○	Sexually Transmitted Disease
NH ○	HH ○	Asthma	NH ○	HH ○	Ulcer
NH ○	HH ○	Sinus Trouble	NH ○	HH ○	Cancer
NH ○	HH ○	Hay Fever	NH ○	HH ○	Polio
NH ○	HH ○	Allergies	NH ○	HH ○	Rheumatic Fever
NH ○	HH ○	Tuberculosis	NH ○	HH ○	Serious Injury
NH ○	HH ○	Diabetes	NH ○	HH ○	Bone Fracture
NH ○	HH ○	Epilepsy	NH ○	HH ○	Dislocated Joints
NH ○	HH ○	Thyroid Trouble	NH ○	HH ○	Spinal Disc Disease
NH ○	HH ○	High Blood Pressure	NH ○	HH ○	Multiple Sclerosis
NH ○	HH ○	Low Blood Pressure	NH ○	HH ○	Scoliosis
NH ○	HH ○	Heart Trouble	NH ○	HH ○	Mental/Emotional Difficulty
NH ○	HH ○	Pacemaker	NH ○	HH ○	Prostate Trouble
NH ○	HH ○	HIV/ARC	NH ○	HH ○	Kidney Trouble
NH ○	HH ○	AIDS	NH ○		Other _____
				HH ○	Other _____

3. Family History

	Cancer	Diabetes	Heart Trouble	High Blood Pres	Stroke	Multiple Sclerosis	Headaches	Neck Problems	Back Problems	Disc Problems	Joint Problems	Arthritis	Pinched Nerve	Osteoporosis	Scoliosis	Bad Posture	Present Age or Age at Death	Deceased
Father	C ○	D ○	H ○	H ○	S ○	M ○	H ○	N ○	B ○	D ○	J ○	A ○	P ○	O ○	S ○	B ○		D ○
Mother	C ○	D ○	H ○	H ○	S ○	M ○	H ○	N ○	B ○	D ○	J ○	A ○	P ○	O ○	S ○	B ○		D ○
Bro 1	C ○	D ○	H ○	H ○	S ○	M ○	H ○	N ○	B ○	D ○	J ○	A ○	P ○	O ○	S ○	B ○		D ○
Bro 2	C ○	D ○	H ○	H ○	S ○	M ○	H ○	N ○	B ○	D ○	J ○	A ○	P ○	O ○	S ○	B ○		D ○
Bro 3	C ○	D ○	H ○	H ○	S ○	M ○	H ○	N ○	B ○	D ○	J ○	A ○	P ○	O ○	S ○	B ○		D ○
Sis 1	C ○	D ○	H ○	H ○	S ○	M ○	H ○	N ○	B ○	D ○	J ○	A ○	P ○	O ○	S ○	B ○		D ○
Sis 2	C ○	D ○	H ○	H ○	S ○	M ○	H ○	N ○	B ○	D ○	J ○	A ○	P ○	O ○	S ○	B ○		D ○
Sis 3	C ○	D ○	H ○	H ○	S ○	M ○	H ○	N ○	B ○	D ○	J ○	A ○	P ○	O ○	S ○	B ○		D ○
Child 1	C ○	D ○	H ○	H ○	S ○	M ○	H ○	N ○	B ○	D ○	J ○	A ○	P ○	O ○	S ○	B ○		D ○
Child 2	C ○	D ○	H ○	H ○	S ○	M ○	H ○	N ○	B ○	D ○	J ○	A ○	P ○	O ○	S ○	B ○		D ○
Child 3	C ○	D ○	H ○	H ○	S ○	M ○	H ○	N ○	B ○	D ○	J ○	A ○	P ○	O ○	S ○	B ○		D ○

E. OCCUPATIONAL INFORMATION - ACTIVITIES OF DAILY LIVING

1. Job Type

○Full Time ○Temporary
○Part Time ○Other _____

2. Work Week

Hours Per Day	1 ○	2 ○	3 ○	4 ○	5 ○	6 ○	7 ○	8 ○	9 ○	10 ○	11 ○	12 ○	
Days Per Week	1 ○	2 ○	3 ○	4 ○	5 ○	6 ○	7 ○						

○Other _____

3. Do Your Present Complaints Affect The Number Of Hours You Work Per Day ○Yes ○No

4. Length Of Time At Present Occupation

Years	10 ○	20 ○	30 ○	40 ○	50 ○						
	1 ○	2 ○	3 ○	4 ○	5 ○	6 ○	7 ○	8 ○	9 ○		
Months	1 ○	2 ○	3 ○	4 ○	5 ○	6 ○	7 ○	8 ○	9 ○	10 ○	11 ○

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