PREVIOUS TREATMENTS

Previous treatments for this condition, including self-treatment: _____

_____

Have you had X-Rays and/or MRIs of this area within the past 5 years? ◊ YES ◊ NO

If YES, we may need to contact your doctor for a copy of all studies. Dr. _____

Address_____ Phone_____

MEDICATIONS

Medication	Reason	Year Started

SURGICAL HISTORY

Year:	Surgery:	Outcome:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

SOCIAL HISTORY

Alcohol: _____ None _____Drinks/week

Tobacco: _____None_____ Cigarettes / Packs (circle one) per day.

Caffeine: _____None _____Cups of Coffee / Tea / 12 oz. Sodas (circle one) per day.

Exercise: _____None _____Mild _____ Moderate _____Heavy

Things you do for fun/relaxation: _____

FAMILY MEDICAL HISTORY

*Place **X** if applies to you, or indicate; **F**ather, **M**other, **B**rother, **S**ister, **G**randparent

Diabetes_____ Stroke_____ Hypertension_____ Cancer_____ Heart Disease_____ Psoriasis_____ Lupus_____

Headache/Migraine_____ Rheumatoid Arthritis_____ Asthma_____ IBS_____ M.S._____ GURD_____ Gout_____

Acid Reflux_____ Mental Illness_____ Epilepsy_____ Allergies_____ Bleeding Disorders_____ Thyroid Dis._____

Miscarriage_____

Is there a possibility you are pregnant? ◊ YES ◊ NO Due Date _____

NOTES

_____

_____

_____