Personal Medical History Template

DHBSFG DIKDAY

Birth Date

10/8/2014

Description of problem or complaints:

head ache
fever
body pain
vomiting

Have you previously been treated for this condition? If yes, by whom?

no

Are your present problems due to an injury? if yes, please select from the list.

Personal Injury

If this is an accident has it been reported? If yes, to whom?

Auto Carrier

Are you now or have you ever been disabled?

No

Family History

Diabetes

Father

Heart Disease

Mother

Kidney Disease

Mother

Habits

Coffee, # of cups per day

0

Smoking, # of packs per day

0.5

Alcohol, # of drinks per week

0

Questions about Job

Job description:

softwere developer

How many hours do you sit per day?

8

How many hours do you stand per day?

2

Please mark if you ever had any of the following:

Appendicitis

Chicken Pox

General Symptoms

Mark the correct box for each symptom listed below:

Allergy	Never
Convulsions	Never
Dizziness	Never
Fainting	Previously
Fatigue	Previously
Headache	Previously
Nervousness	Previously
Neuralgia	Never
Numbness	Never
Pain in arms/legs/hands	Previously

Have you missed any work as a result of the accident? If so, how many days?

3

Muscles and Joints

Mark the correct box for each symptom listed below:

Backache	Previously
Foot trouble	Previously
Hernia	Never
Pain between shoulders	Previously
Painful tail bone	Never
Stiff neck	Never
Spinal curvature	Never
Swollen joints	Never
Tremors	Never
Twitching	Never
Weakness	Previously

Cardiovascular

Mark the correct box for each symptom listed below:

High blood pressure	Previously
Low blood pressure	Never
Pain over heart	Never
Poor circulation	Never
Previous heart trouble	Never
Stroke	Never
Swelling of ankles	Never
Varicose veins	Never
Chest pain	Never
Chronic cough	Never
Difficulty breathing	Never

Operations and Procedures

Vaccination
2022

Appendectomy
2018

General

Have you ever had Chiropractic care before?

No

List any broken bones (fractures) or dislocation:

left arm broken

Have you ever had any spinal taps/spinal injections?

No

Do you suffer from any other condition other than for which you are now consulting us for?

no

Consent

I hereby authorize the company to examine and treat my condition as deemed appropriate through the use of Chiropractic Care, and give authority for these procedures to be performed. It is understood and agreed the amount paid to the Doctor for Xrays is for examination only and the Xray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of the office. The patient also agrees that he/she is responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

Signature

Date and Time

Wednesday, August 21, 2024 10:40