

**TAYLOR CHIROPRACTIC**  
**PATIENT INTRODUCTION FORM AND HEALTH HISTORY**

**TODAY'S DATE:**

\_\_\_\_\_

**PERSONAL**

Full legal name: \_\_\_\_\_ Current address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_ Home phone #: \_\_\_\_\_ Work phone #: \_\_\_\_\_

e-mail address: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_ Social Security # \_\_\_\_\_ Sex: M F

Marital status (circle one) M S W D Name of spouse (if married) \_\_\_\_\_

Your place of employment: \_\_\_\_\_ Your occupation: \_\_\_\_\_

If you are under 19, your parent/guardian: \_\_\_\_\_

Number and age(s) of children: \_\_\_\_\_

Name of nearest relative not living with you (in case of emergency) \_\_\_\_\_

City: \_\_\_\_\_ Telephone # \_\_\_\_\_

**CURRENT HEALTH**

What are your chief symptoms?: \_\_\_\_\_

Secondary complaints?: \_\_\_\_\_

When did your problem begin?: \_\_\_\_\_

How did it begin? (check one) Auto Accident \_\_\_\_\_ Work Related \_\_\_\_\_ Other \_\_\_\_\_ (please describe) \_\_\_\_\_

What doctors have you seen for this problem?: \_\_\_\_\_

Have you lost work due to this problem? (if yes, please give dates): \_\_\_\_\_

Have you had any surgeries or been hospitalized for this problem?: \_\_\_\_\_

Are you currently under treatment for any other conditions? (if yes, please describe): \_\_\_\_\_

Who is your physician?: \_\_\_\_\_ City: \_\_\_\_\_ Phone: \_\_\_\_\_

Have you had chiropractic care for this or any other condition?(if yes, please describe): \_\_\_\_\_

Please list any allergies: \_\_\_\_\_ Females, are you pregnant? \_\_\_\_\_ Date of last menstrual period: \_\_\_\_\_

Date of your last visit to your physician: \_\_\_\_\_

**PLEASE TURN OVER AND COMPLETE THE BACK OF THE FORM**

**PERSONAL AND SOCIAL HISTORY**

Please list all medications you are taking (including over-the-counter remedies or birth control pills): \_\_\_\_\_

Please list any fractures or dislocations: \_\_\_\_\_

Have you ever been diagnosed as having or suffering from: (Place a check mark by conditions that apply to you)

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Osteoarthritis           | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Drug Addiction |
| <input type="checkbox"/> Circulatory Problems     | <input type="checkbox"/> Epilepsy        | <input type="checkbox"/> Alcoholism     |
| <input type="checkbox"/> Rheumatoid Arthritis     | <input type="checkbox"/> Tumors          | <input type="checkbox"/> Depression     |
| <input type="checkbox"/> Seizures/Convulsions     | <input type="checkbox"/> Strokes         | <input type="checkbox"/> HIV Positive   |
| <input type="checkbox"/> A Congenital Disease     | <input type="checkbox"/> Cancer          | <input type="checkbox"/> Gall Bladder   |
| <input type="checkbox"/> Excessive Bleeding       | <input type="checkbox"/> Ruptures        | <input type="checkbox"/> Head Injury    |
| <input type="checkbox"/> High/Low Blood Pressure  | <input type="checkbox"/> Coughing Blood  | <input type="checkbox"/> Ulcers         |
| <input type="checkbox"/> Do you wear a pacemaker? |  |   |

Do you drink alcoholic beverages? \_\_\_\_\_ Do you smoke? \_\_\_\_\_ Do you take vitamin supplements? \_\_\_\_\_

Do you exercise? \_\_\_\_\_ If yes, frequency and type of exercise: \_\_\_\_\_

Do you have a history of stroke? \_\_\_\_\_

Please list any other health problems you have, no matter how insignificant they may be: \_\_\_\_\_

**FAMILY HISTORY**

**PARENTS:**

Father: living \_\_\_\_\_ (current age \_\_\_\_\_) deceased \_\_\_\_\_  
Cause of death and age at death if deceased: \_\_\_\_\_

Mother: living \_\_\_\_\_ (current age \_\_\_\_\_) deceased \_\_\_\_\_  
Cause of death and age at death if deceased: \_\_\_\_\_

OR

(Check if applicable to you): \_\_\_\_\_ As an adopted child, little is known of birth parents or family.

**FAMILY DISEASES** (check if applicable and indicate whether family member is Father, Mother, Sister, Brother):

TB \_\_\_\_\_ Cancer \_\_\_\_\_ Mental Illness \_\_\_\_\_ Diabetes \_\_\_\_\_ Asthma \_\_\_\_\_

Heart Disease \_\_\_\_\_ Stroke \_\_\_\_\_ Kidney Disease \_\_\_\_\_ Lung Disease \_\_\_\_\_

Arthritis \_\_\_\_\_ Liver Disease \_\_\_\_\_ Other \_\_\_\_\_

