Please list any serious injuries or surgeries you have had in your lifetime:

	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		
Other Serious Injuries		

Women: Are you Pregnant? L Yes L No If so, How far along? _____ Nursing? L Yes L No

Have you had any of the following conditions?

L Heart Attack/ Stroke
L Congenital Heart Defect
L Alcohol/Drug Abuse
L Shingles
L Osteoporosis
L Menstrual Problems
L Pain Unrelieved by Position or Rest
L Fainting/Seizures/Epilepsy
L Emphysema/Glaucoma
L Kidney Problems
L Artificial Bones/Joints
L Cancer
L Other _____

L Arthritis
L Frequent Neck Pain
L Jaw Pain
L Corticosteroid Use (cortisone, prednisone, etc.)
L Urinary Problems
L Pain at Night
L Wrist Pain
L Psychiatric Problems
L Difficulty Breathing
L Hepatitis
L Anemia

L Ringing in Ears Ulcer/Colitis
L Sever/Frequent Headaches
L Diabetes/Tuberculosis
L Recent Fever
L Prostate Problems
L Abnormal Weight L Gain L Loss
L Visual Disturbances
L Dizziness
L Arm Pain
L Leg Pain
L Lower Back Problems
L Sever/Frequent Earaches
L Muscle Spasms, Where? _____

L High Blood Pressure
L Gout
L Numbness, where? _____
L Marked Morning Pain/ Stiffness
L Shoulder Pain
L Tingling, where? _____
L HIV Positive/AIDS

Medications/ Nutrition: _____

Personal Habits:

	Heavy	Moderate	Light	None
Alcohol	L	L	L	L
Coffee	L	L	L	L
Tobacco	L	L	L	L
Drugs	L	L	L	L
Exercise	L	L	L	L
Sleep	L	L	L	L
Appetite	L	L	L	L

Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the chiropractor, Dr. Lisa DeForest, to help determine appropriate chiropractic treatment. If there is any change in my medical status, I will inform my chiropractor.

Signature: _____ Date: _____