Townsend Chiropractic & Wellness Center

Medical History

Have you been treated for any conditions in the last year? Yes ____ No_____
If yes, please describe____
Date of last physical exam_________ Is there a chance that you are pregnant? Yes __ No__
Have you had x-rays taken? Yes___ No___ If yes, where?____________________________
What medications are you taking and for what conditions (Please list dosage and amounts, etc).____
____
What vitamins, minerals or herbs do you currently take? (Please list for what condition, dosage, and frequency).____
____

Have you ever:	No	Yes	Briefly Explain
Broken bones?	☐	☐	________________
Been hospitalized?	☐	☐	________________
Been in an auto accident?	☐	☐	________________
Had sprains/strains?	☐	☐	________________
Been struck unconscious?	☐	☐	________________
Had surgery?	☐	☐	________________

Family History

Family Member **Present and past health conditions (Example: heart disease, cancer, diabetes, arthritis, etc).**

____
____
____

Habits:	None	Light	Moderate	Heavy
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐
Soft Drinks	☐	☐	☐	☐
Water	☐	☐	☐	☐
Salty Foods	☐	☐	☐	☐
Sugary Foods	☐	☐	☐	☐
Artificial Sweeteners	☐	☐	☐	☐

	Yes	No
Do you experience pain every day?	☐	☐
Do your symptoms interfere with daily life?	☐	☐
Does pain wake you up at night?	☐	☐
Are your symptoms worse during certain times of the day?	☐	☐
Do changes in weather affect your symptoms?	☐	☐
Do you wear orthotics?	☐	☐
Do you take vitamin supplements?	☐	☐

What symptoms aggravate your symptoms?
____
____

Name: **ID#**

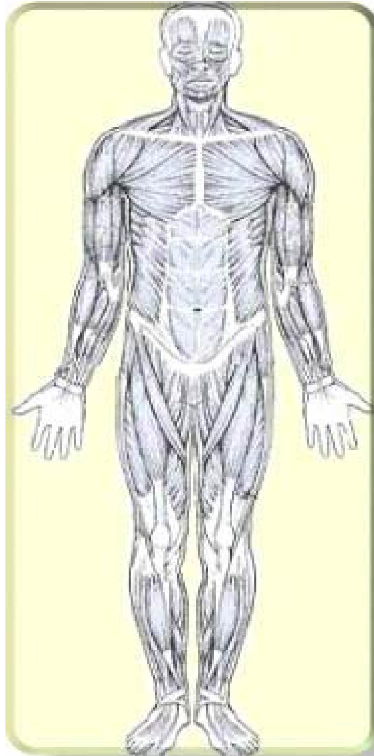
Have you ever suffered from:

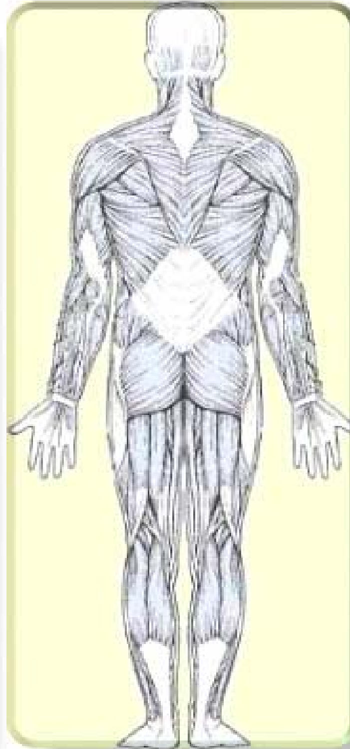
Alcoholism	☐	Excessive Menstruation	☐	Nosebleeds	☐
Allergies	☐	Eye Pain/Difficulties	☐	Pacemaker	☐
Arteriosclerosis	☐	Fatigue	☐	Polio	☐
Arthritis	☐	Frequent Urination	☐	Poor Posture	☐
Asthma	☐	Headache	☐	Prostate Trouble	☐
Back Pain	☐	Hemorrhoids	☐	Sciatica	☐
Breast lump	☐	High Blood Pressure	☐	Shortness of Breath	☐
Bronchitis	☐	Hot Flashes	☐	Sinus infection	☐
Bruise easily	☐	Irregular Heart Beat	☐	Sleep problems	☐
Cancer	☐	Irregular cycle	☐	Spinal Curvatures	☐
Chest Pain/Conditions	☐	Kidney Infection	☐	Stroke	☐
Cold extremeties	☐	Kidney Stones	☐	Swelling of ankles	☐
Constipation	☐	Loss of memory	☐	Swollen joints	☐
Cramps	☐	Loss of balance	☐	Thyroid Condition	☐
Depression	☐	Loss of smell	☐	Tuberculosis	☐
Diabetes	☐	Loss of taste	☐	Ulcers	☐
Digestion Problems	☐	Lumps in Breast	☐	Varicose Veins	☐
Dizziness	☐	Neck Pain or Stiffness	☐	Venereal Disease	☐
Ears Ring	☐	Nervousness	☐	Other	☐

Current Complaints

Please use the following letters to indicate TYPE and LOCATION of the symptoms you are currently experiencing.

A=Ache	O=Other
B=Burning	P=Pins & Needles
N=Numbness	S=Stabbing





Name: **ID#**