Bowman Chiropractic

Medical History Information

Last Name: First Name:	Middle:	❑ Mr. ❑ Mrs.		❑ Miss ❑ Ms.	Marital status Single / Mar / Div / Sep / Widow
Email:			Birth date:	Age:	Sex:
Address:		City:		State:	
ZIP Code:	Social Security No.:		Home Phone:		
Occupation:		Employer:		Employer phone:	

Medical Care Information

Do You Have a Family Doctor?: ☐ No ☐ Yes, Name of Doctor:

Address:		City:	State:	ZIP Code:
Date of last Visit: / /		Date of last exam: / /		

Do You Have a Family Chiropractor?: ☐ No ☐ Yes, Name of Chiropractor:

Address:		City:	State:	ZIP Code:
Date of last Visit: / /		Date of last exam: / /		

Have you had surgeries in the last 5 Years: ☐ Yes ☐ No If yes, Last Surgery Date:

Reason for Surgery:

Present illness /Conditions:

☐ AIDS	☐ Cancer	☐ Heart Problem		☐ Multiple Sclerosis	☐ Spinal Disc Disease	
☐ Allergies	☐ Cirrhosis/hepatitis	☐ High blood pressure		☐ Pacemaker	☐ Thyroid trouble	☐ Epilepsy
☐ Anemia	☐ Diabetes	☐ HIV/ARC		☐ Prostate trouble	☐ Tuberculosis	☐
☐ Arthritis	☐ Dislocated joints	☐ Kidney trouble		☐ Rheumatic fever	☐ Ulcer	☐
☐ Asthma	☐ Diverticulitis	☐ Low Blood Pressure		☐ Scoliosis	☐ Polio	☐
☐ Bone fracture	☐ Hay Fever	☐ Mental/ Emotional Difficulty		☐ Sinus trouble	☐ STD'S	☐

Other:

Family History of illness:

☐ AIDS	☐ Cancer	☐ Multiple Sclerosis		☐ Spinal Disc Disease	☐ STD'S	
☐ Allergies	☐ Bone fracture	☐ Heart Problem		☐ Low Blood Pressure	☐ Sinus trouble	☐ Ulcer
☐ Anemia	☐ Cirrhosis/hepatitis	☐ HIV/ARC		☐ Mental/ Emotional Difficulty	☐ Epilepsy	☐ Polio
☐ Arthritis	☐ Diabetes	☐ High blood pressure		☐ Prostate trouble	☐ Thyroid trouble	☐ Scoliosis
☐ Asthma	☐ Dislocated joints	☐ Kidney trouble		☐ Rheumatic fever	☐ Tuberculosis	☐ Diverticulitus

Other:

Type of Cancer: ☐ Breast ☐ Lung ☐ Other:

Social History:

Alcohol? ☐ No ☐ Yes Drinks per week?	Cigarettes? ☐ No ☐ Yes Packs per day?	Caffeine? ☐ No ☐ Yes Drinks per day?		Exercise? ☐ No ☐ Yes Hours per week? (circle one) Light / Moderate / Strenuous

Signature.: Date: