UNIVERSITY of WESTERN STATES
Health Centers

Patient's name: _____ **DOB** _____ **Date** _____

Welcome to the University of Western States clinic. Please fill out both sides of this form. The information you provide will help your physician determine whether Chiropractic treatment will be of benefit to you. All information will be kept strictly confidential.

Is your injury work related or a result of a motor vehicle accident? □ **No** □ **Yes Date of Injury** _____

Chief Complaint:

List your current health concerns	How long have you had this condition?

Hospitalizations/Surgeries:

When	For what condition?	Do you have any residual effects?

Medications: (prescription, over the counter supplements, etc.)

Medication	dose	For what condition?

Allergies: (Medications, environmental, foods, etc)

What are you allergic to?	What reaction?

Past Medical History: Have you ever had any of the following conditions (**circle all that apply**)?

Allergies	Anemia	Anxiety
Arthritis	Asthma	Blood transfusion
Cancer	Cataracts	CHF
Clotting disorder	COPD	Depression
Diabetes	Emphysema	GERD
Glaucoma	Heart murmur	HIV/AIDS
Hypertension	Kidney disease	Meningitis
Heart attack	Nerve or muscle disease	Osteoporosis
Seizure	Sickle cell anemia	Stroke
Substance abuse	Thyroid condition	Tuberculosis
Ulcers		
Other:		

Past Surgical History: Have you ever had any of the following conditions (**circle all that apply**)?

Appendectomy	C-Section	Prostate surgery
Brain surgery	Eye surgery	Small intestine surgery
Breast surgery	Fracture surgery	Spine surgery
CABG	Hernia repair	Tubal ligation
Cholecystectomy	Hysterectomy	Valve replacement
Colon surgery	Joint replacement	Vasectomy
Cosmetic surgery		
Other:		

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Family Health History:

Relative	Age	Age at onset	Disease(s)	If deceased(cause of death)
Your mother				
Your father				
Your mother's mother				
Your mother's father				
Your father's mother				
Your father's father				
Your brother(s)				
Your sister(s)				
Your children				
Were you adopted?			□ Yes	

Do you drink alcohol? □ Yes □ No

What type of alcohol?	# of drinks per week
Glasses of wine	
Cans / bottles of beer	
Shots of liquor	
Drinks containing 0.5 oz alcohol	

Do you use Tobacco? □ Yes □ No **Have you ever?** □ Yes □ No **Quit date** _____

Are you interested in quitting? □ Yes □ No

Type of tobacco	amount of use per day	Duration of use (# years)
Cigarettes		
Cigar		
Pipe		
Snuff		
Chew		

Do you use non-prescription drugs? □ Yes □ No

What type of drugs do you use? (circle all that apply):

Crack, cocaine, ecstasy, IV, Heroin, LSD, Marijuana, Methamphetamine Other:_____

Are you sexually active? □ Yes □ No

Do you use birth control? □ Yes □ No

Birth control / Protection method: Abstinence, cervical cap, condom, diaphragm, Hormone patch, implant, injection, inserts, IUD, IUS, Pill, rhythm, spermicide, sponge, surgical, vaginal ring, withdrawal, none.

Do you exercise? □ Yes □ No

What type of exercise?	How long and how often do you exercise (e.g. 3x/wk/30 min)

Is there anything else we can help you with or you'd like to tell us that we haven't addressed on this form?

_____

_____

_____

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