

Ability for Health and Wellness Chiropractic Clinic
11 Office Park Drive, Little Rock, 72211
501-224-2242

Personal Health History

Today's Date: _____

1. Name: _____

2. Referred by: _____

3. Medications:

Name	Dosage	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____

4. Past History: A diagnosis from a physician for any of the following?

- | | |
|-----------------------------|-----------------------------------|
| (yes/no) Cancer of any type | (yes/no) Arthritis |
| (yes/no) Stroke | (yes/no) Disc problems |
| (yes/no) Hepatitis | (yes/no) High Blood Pressure |
| (yes/no) Heart Problems | (yes/no) HIV or AIDS |
| (yes/no) Migraine Headaches | (yes/no) Urinary Tract Infections |
| (yes/no) Diabetes | (yes/no) Tuberculosis |
| (yes/no) Kidney Problems | (yes/no) Obesity |
| (yes/no) Fracture | (yes/no) Osteoporosis |

5. Past Surgical History: Have you had any of the following?

- | | | | |
|-------------------------|-------------------------|-----------------------|----------|
| (yes/no) Spinal Surgery | Neck | Mid Back | Low Back |
| (yes/no) Colon Surgery | | | |
| (yes/no) Heart Surgery | | | |
| (yes/no) Hysterectomy | Was it for cancer? ____ | Ovaries removed? ____ | |

6. Family History: Any of the following occur in your family? If so, please list relationship, age of onset, and if living or deceased.\

- | | |
|-----------------------------|-------|
| (yes/no) Cancer of any type | _____ |
| (yes/no) Heart Disease | _____ |
| (yes/no) Liver Disease | _____ |
| (yes/no) Diabetes | _____ |
| (yes/no) Kidney Disease | _____ |
| (yes/no) Stroke | _____ |
| (yes/no) Back Pain | _____ |

7. Social History

- (yes/no) Do you regularly drink alcohol? If so, how many drinks per week? ____
- (yes/no) Do you regularly smoke? How many packs per day? _____

Signature: _____ Date: _____