OWENSBORO
CHIROPRACTIC & FAMILY PRACTICE

Reason for Visit

_____

_____

_____

_____

Past Medical History (Check All That Apply)

_____Anxiety	_____Cancer (Type)	_____Heart Disease	_____Skin Disease
_____Asthma	_____Cholesterol	_____Hypertension	_____Stomach Problems
_____ADD	_____COPD	_____IBS	_____Stroke
_____ADHD	_____Depression	_____Joint Disease	_____TB
_____Alcoholism	_____Diabetes (Type)	_____Kidney Disease	_____Thyroid Disease
_____Bipolar	_____Epilepsy/Seizures	_____Kidney Stones	☐ Hypo ☐ Hyper
_____Bladder Problems	_____GERD/Reflux	_____Liver Disease	_____Stroke
_____Blood Clots	_____Gout	_____Prostate Disease	
_____Bowel Problems	_____Heart Attack	_____Psychiatric Disorder	

Other:_____

Past Surgical History (Please Check All That Apply and List Dates if Possible)

Surgery	Date	Surgery	Date
_____Appendix		_____Hysterectomy (partial/total)	
_____Back		_____Kidney	
_____Bladder		_____Laparoscopy (type)	
_____Breast (Type)		_____Prostate	
_____C-Section		_____Tonsils	
_____Cataract		_____Thyroid	
_____Skin Biopsy (Location)		_____Nerosurgery	
_____Gallbladder			
_____Hernia			

Medical History

Smoke ☐ Yes ☐ No (How Much)_____

Have You Ever Smoked? ☐Yes ☐No If yes when?_____

Drink ☐ Yes ☐ No (How Much)_____

Recreational Drug Use (Type)_____

Have You Used Drugs In The Past 3 Months? ☐ Yes ☐ No

OTC Vitamins_____

Employed ☐ Yes ☐ No

Retired ☐ Yes ☐ No

Disabled ☐ Yes ☐ No

Number of Children_____

Preventative Maintance (Please List Dates if Possible)

	Date
Pap Smear	
Mammogram	
Bone Density	
EKG	
Prostate Exam	
Colonoscopy	
Eye Exam	
X-Ray (Type)_____	
Routine Blood Work	
PSA	
Vaccines	

Family History

Mother: ☐ Living ☐ Deceased

Mother's Medical History_____

Father: ☐ Living ☐ Deceased

Father's Medical History_____

Signature:_____ Date:_____

If Not a Patient, Relationship:_____

For Office Use Only:

Patient# _____ | Insurance Eligibility: [ ] | EMR Scanned: [ ] | HIPPA Ack [ ]

* Indicates a required field