Morgan Chiropractic Center

Name: ____ **Height:** _______________ **Weight:**___________

Please list any Previous Illnesses and Major Injuries:

Year __________ Type ____ Residual Problem __________________________________

Year __________ Type ____ Residual Problem __________________________________

Year __________ Type ____ Residual Problem __________________________________

Year __________ Type ____ Residual Problem __________________________________

Year __________ Type ____ Residual Problem __________________________________

Please list any Surgeries and Hospitalization:

Year __________ Type ____ Residual Problem __________________________________

Year __________ Type ____ Residual Problem __________________________________

Year __________ Type ____ Residual Problem __________________________________

Year __________ Type ____ Residual Problem __________________________________

Year __________ Type ____ Residual Problem __________________________________

Please list all Medications, Nutritional Supplements (S), Vitamins (V), and Over the Counter Drugs (OTC):

Medication ___________________________ Milligrams/Day ________ S,V,OTC _________________________ Milligrams/Day ________

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Medication ___________________________ Milligrams/Day ________ S,V,OTC _________________________ Milligrams/Day ________

Medication ___________________________ Milligrams/Day ________ S,V,OTC _________________________ Milligrams/Day ________

Medication ___________________________ Milligrams/Day ________ S,V,OTC _________________________ Milligrams/Day ________

Please list all known Allergies: ____

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Family Medical History:

Has any relative ever had the following? (Please circle)

Cancer	Father	Mother	Sister	Brother	Son	Daughter	Grandmother (Maternal/Paternal)	Grandfather (Maternal/Paternal)
Diabetes	Father	Mother	Sister	Brother	Son	Daughter	Grandmother (Maternal/Paternal)	Grandfather (Maternal/Paternal)
Heart Disease	Father	Mother	Sister	Brother	Son	Daughter	Grandmother (Maternal/Paternal)	Grandfather (Maternal/Paternal)
Heart Failure	Father	Mother	Sister	Brother	Son	Daughter	Grandmother (Maternal/Paternal)	Grandfather (Maternal/Paternal)
High Blood Pressure	Father	Mother	Sister	Brother	Son	Daughter	Grandmother (Maternal/Paternal)	Grandfather (Maternal/Paternal)
Kidney Disease	Father	Mother	Sister	Brother	Son	Daughter	Grandmother (Maternal/Paternal)	Grandfather (Maternal/Paternal)
Stroke	Father	Mother	Sister	Brother	Son	Daughter	Grandmother (Maternal/Paternal)	Grandfather (Maternal/Paternal)

Social History: (Please circle)

Marital Status:	Single	Married	Separated	Divorced	Widowed	
Employment Status:	Employed	Homemaker	Retired	Unemployed	Student	
Domicile:	Live Alone	Live with spouse	Live with other			
Smoking Status:	Never	Current every day	Current some days	Former smoker	Light smoker	Heavy smoker
Alcohol:	None	Casual	Moderate	Heavy	Drinks beer	Drinks wine
Caffeine:	None	< 3 drinks/day	3-6 drinks/day	> 6 drinks/day		
Drug use:	None	Recreational user	Addiction			
Exercise:	Never	Daily	Weekly			