Patients Name:_____

MEDICAL/FAMILY HISTORY

Please indicate which conditions have been experienced by yourself and/or family by marking the appropriate boxes.

S=Self, M=Mother, F=Father, G=Grandparents.

S M F G	S M F G	S M F G
□□□□Addiction	□□□□ Dislocated Joints	□□□□ Nervousness
□□□□AIDS	□□□□Epilepsy	□□□□Numbness
□□□□Alzheimer's	□□□□German Measles	□□□□Pneumonia
□□□□Arthritis	□□□□Headaches	□□□□Polio
□□□□Asthma	□□□□Heart Disease	□□□□Poor Circulation
□□□□Back Pain	□□□□Reproductive Disorder	□□□□Parkinson's
□□□□Bladder Trouble	□□□□High Blood Pressure	□□□□Rheumatic Fever
□□□□Bone Fracture	□□□□HIV/ARC	□□□□Rheumatism
□□□□Cancer	□□□□Kidney Disorder	□□□□Scarlet Fever
□□□□Chest Pain	□□□□Lung Disorder	□□□□Serious Injury
□□□□Concussion	□□□□Bowel Control Loss	□□□□Sinus Trouble
□□□□Convulsions	□□□□Menstrual Cramps	□□□□Stroke
□□□□Diabetes	□□□□Multiple Sclerosis	□□□□Tuberculosis
□□□□Hepatitis	□□□□Muscular Dystrophy	□□□□Thyroid Disorder
□□□□Indigestion	□□□□Neck Pain	□□□□Venereal Disease

When were you treated by a physician for any health condition(s)?_____
Describe Condition(s)_____
_____
_____

When were the last of the following and were they normal?

Physical Exam_____ Breast Exam_____
Spinal X-Ray_____ Blood Test_____
PAP Smear_____ Mammogram_____
Pelvic Exam_____ Prostate Exam_____

Describe any injuries you have ever had, including minor auto accidents:

Fall:_____ Date:_____
Head Injuries:_____ Date:_____
Broken Bones:_____ Date:_____
Dislocations:_____ Date:_____
Auto Accidents:_____ Date:_____
_____ _____
Other:_____ Date:_____

Surgical History: List any surgeries that you have ever had.

1. _____ Date:_____
2. _____ Date:_____
3. _____ Date:_____

Have you ever had a metal implant? □ Yes □ No Ever been gunshot? □ Yes □ No

Patients Name:_____

Accident History: List any accidents that you have ever had.

1. □Job□Auto□Other_____ Date:_____
2. □Job□Auto□Other_____ Date:_____
3. □Job□Auto□Other_____ Date:_____

Exercise: (circle one)	Work Activity (circle all that apply)	Habits
Daily	Sit Mostly	Smoke_____/day for _____years
3-5 times/wk	Stand Mostly	Alcohol_____drinks/day/week/month
1-2 times/wk	Heavy Lifting	Coffee_____drinks/day
Not at all	Light Lifting	Sugar_____amount
	Lots of twisting	Chew_____cans/day/week/month
	Some of the above	Stress_____High_____Medium_____Low

Have you ever been hospitalized before? □ Yes □ No Date(s)_____
_____
_____
_____
_____

Are you allergic to any medications, herbs, and/or foods? □ Yes □ No If Yes, please list? _____
_____
_____

Are you taking any medications? □ Yes □ No If yes, please list.

Medications	Vitamins/Herbs
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Have you seen a Chiropractor before? □ Yes □ No
If yes, who and date of last visit?_____

Have you seen an Acupuncturist before? □ Yes □ No
If yes, who and date of last visit?_____

Do you know of anyone who could benefit from Chiropractic or Acupuncture care??

Name_____ Name_____
Address_____ Address_____
_____ _____
Phone_____ Phone_____

Notes:
_____
_____
_____

Abundant Health, LLC – 731 Bookcliff Ave. – Grand Junction, Co. 81501 – (970) 256-7454

Patients Name:_____

Please Describe Present Major Complaints

Please list and rate your symptoms. (0-10, with 0 being no pain to 10 being worse pain of your life)

1._____	0 1 2 3 4 5 6 7 8 9 10
2._____	0 1 2 3 4 5 6 7 8 9 10
3._____	0 1 2 3 4 5 6 7 8 9 10
4._____	0 1 2 3 4 5 6 7 8 9 10
5._____	0 1 2 3 4 5 6 7 8 9 10
6._____	0 1 2 3 4 5 6 7 8 9 10

Symptoms are worse in : ☐Morning ☐Afternoon ☐Night
When and how occurred?_____
_____

Symptoms developed from:
☐Job Related Injury ☐Auto Accident ☐Accident ☐Illness
☐Unknown Cause ☐Gradual Onset ☐Other Date Occurred_____

Symptoms have persisted for: #_____hour(s) _____day(s) _____week(s) _____month(s) _____year(s)

Symptoms/complaints: ☐Come & Go ☐Are Constant

Have you ever had this before? ☐Yes ☐No If Yes, when?_____

If you were to guess, what do you think is causing your complaints?_____
_____

Name and location of doctors previously seen for present condition(s):
_____
_____

Are you pregnant? ☐Yes ☐No ☐N/A If yes, please answer the following:
Date of LMP _____ Ultrasounds this pregnancy, ☐Yes ☐No If Yes, how many?_____
Live Births_____ Miscarriages_____ Abortions_____ Living Children_____

Please check the following activities that aggravate your condition:

☐Bending	☐Reaching	☐Straining at Stool	☐Coughing
☐Sitting	☐Turning Head	☐Lifting	☐Sneezing
☐Walking	☐Lying Down	☐Standing	

Please check the following activities that relieve your condition:

☐Bending	☐Sitting	☐Lifting	☐Standing
☐Lying Down	☐Turning Head	☐Reaching	☐Walking
☐Ice	☐Heat	☐Medication	

Please Check any additional symptoms you may be experiencing:

☐ Blurred Vision	☐ Depression/Weeping	☐ Fever	☐ Loss of Smell
☐ Pins & Needles in Arms			
☐ Buzzing in Ears	☐ Diarrhea	☐ Head Seems Heavy	☐ Loss Of Taste
☐ Pins & Needles in Legs			
☐ Cold Feet	☐ Dizziness	☐ Headaches	☐ Low Resist. To Colds
☐ Ringing In Ears			
☐ Cold Hands	☐ Face Flushed	☐ Insomnia	☐ Muscle Jerking
☐ Shortness Of Breath			

☐ Cold Sweats	☐ Fainting	☐ Light Bothers Eyes	☐ Numbness In Fingers	☐ Stiff Neck
☐ Concentrations Loss	☐ Fatigue	☐ Loss of Balance	☐ Numbness In Toes	☐ Stomach Upset
☐ Constipation				

Patient's Signature:_____ Date:_____