Sitzmann Chiropractic, LLC (864) 458-8888 Greenville, SC

Patient Medical History

Patient Name:______________________________ D.O.B. ____________

Current Condition:

Describe Major Complaint(s):______________________________

Began When? ___/____/_____ Describe how this began:______________________________

Height: _______ Weight: _______ Drug Allergies: ______________________________

Current Prescription Medications:

____

Past Medical History: Please list all current medical issues including surgeries in the last 10 years

____

____

(If necessary, continue on back of page)

Social History:

How is your diet? __Poor ___Average __Good diet ___Excellent Diet

Do you exercise? ___No ___Yes→ If yes, how often? ______________________________

Do you currently smoke? ___**Never** ____No ____Yes → If yes, how many packs per day _________

Do you drink alcohol? ____No ____Yes → If yes, how often? ______________________________

Family History:

Do your parents currently have or have they ever had any of the following health problems:

____Alzheimer's ____Arthritis ____Asthma ____Cancer: ________________________
____CAD ____Cholesterol Issues ____Depression ____Diabetes ____Hypertension ____Migraines
____Obesity ____Osteoporosis ____Kidney Disease ____Stroke ____Thyroid Disorder ___Unknown

List all Other Family History:

____Alzheimer's ____Arthritis ____Asthma ____Cancer: ________________________
____CAD ____Cholesterol Issues ____Depression ____Diabetes ____Hypertension ____Migraines
____Obesity ____Osteoporosis ____Kidney Disease ____Stroke ____Thyroid Disorder ___Unknown

I hereby certify that the statements and answers given on this form are accurate to the best of my knowledge and I understand it is my responsibility to inform this office of any changes in my health.

Print Name__________________________ **Signature**______________________________**Date**___________