Gilkey Family Chiropractic & Sports Injury Clinic

NAME: _____ DATE: _____

PLEASE CHECK ALL THAT APPLY:

Allergies:

o Animals	o Dairy Products (milk, cheese)	o Molds	o Seasonal Allergies
o X-ray Dye	o Aspirin/Pain Medicine	o Dust	o Penicillin
o Shellfish	o Bee Stings	o Eggs	o Ragweed/Pollen
o Soaps	o Chocolate/Sweets	o Latex	o Rubber
o Wheat	**o NONE**		

OTHER: _____

Previous Surgeries:

o Appendix	o Disc	o Gastrointestinal	o Hip Replacement
o Neurological	o Wrist/Hand	o Back	o EENT
o Gynecological	o Knee	o Obstetrical	o Brain/Tumor
o Elbow	o Heart	o Podiatric	o Carpal Tunnel
o Heart Bypass	o Knee Replacement	o Shoulder	o Cervical Disc
o Foot	o Hernia	o Lumbar Disc	o Thoracic Disc
o Chest	o Gallbladder	o Hip	o Neck

o NONE

OTHER: _____

Medical History:

o Ankle Pain	o Back Pain	o Depression/OtherDisorder**	o Epilepsy
o Foot Pain	o Hearing Problems**	o High Cholesterol	o Knee Pain
o Mid Back Pain	o Neurological Disorder**	o Prostate Problems	o Sprain/Strain**
o Ulcer/s	o Arm Pain	o Broken Bones**	o Diabetes
o Eye/Vision Problems	o Spinal Disorder**	o Heart Problems**	o Hip Pain
o Leg Pain	o Minor Heart Trouble	o Pacemaker	o Shoulder Pain
o Stroke/Heart Attack	o Wrist Pain	o Arthritis	o Cancer**
o Dizziness	o Fainting	o Hand Pain	o Hepatitis
o Jaw Pain	o Low Back Pain	o Multiple Sclerosis	o Parkinson's disease
o Stomach Problems**	o Asthma	o Chest Pain	o Elbow Pain
o Fatigue	o Headaches	o High Blood Pressure	o Joint Stiffness
o Menstrual Problems	o Neck Pain	o Tumor**	o Polio
o Spinal Cord Injury	**o OTHER****	**o NONE**	

** Please explain:

_____

_____

IS THIS VISIT DUE TO AN ACCIDENT?

If YES please circle one of the following:

Auto Boat/Recreational/ Sports/ Other: (please explain) _____

Please Circle One

Are you able to sleep comfortably?	Yes / No	
Are you right or left hand dominant?	Right / Left	
Are you having any weakness?	Yes / No	(if yes please explain):
Are you or could you be pregnant?	Yes / No	Due Date:
Do you currently have a contagious disease?	Yes / No	(if yes please explain):
Do you exercise regularly? (2-3 times per week)	Yes / No	
Do you smoke?	Yes / No	Packs per day:
Do you drink alcohol?	Yes / No	Drinks per week:
Do you drink caffeine?	Yes / No	Drinks per day:
Do you have a high stress level?	Yes / No	Please Circle: Work/ Home/ Other
Do you require support to walk?	Yes / No	

Please list if you have had any of the following:

X-rays:

Date taken:_____ Area_____

Facility taken at: _____

MRI:

Date taken:_____ Area_____

Facility taken at: _____

CT scan:

Date taken:_____ Area_____

Facility taken at: _____

Please List your PCP and any other doctors you have previously seen:

PCP: _____

Name: _____ Specialty: _____

Name: _____ Specialty: _____

Please list any medications you are currently taking:

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____