Wink Chiropractic Wellness Center, S.C.

924 Forest Avenue, Ste 101, Fond du Lac, WI 54935
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Health History

Are you taking any of the following medications?

☐ **NERVE PILLS**	☐ **PAIN KILLERS** (incl. aspirin)	☐ **MUSCLE RELAXERS**	☐ **STIMULANTS**
☐ **BLOOD THINNERS**	☐ **TRANQUILIZERS**	☐ **INSULIN**	☐ **OTHER** _____

Have you ever had any of the following diseases or conditions?

☐ **HEART ATTACK/STROKE**	☐ **HEART SURGERY/PACEMAKER**	☐ **HEART MURMUR**
☐ **CONGENITAL HEART DEFECT**	☐ **MITRAL VALVE COLLAPSE**	☐ **ARTIFICIAL VALVES**
☐ **ALCOHOL/DRUG ABUSE**	☐ **VENEREAL DISEASE**	☐ **HEPATITIS**
☐ **HIV+/AIDS**	☐ **SHINGLES**	☐ **CANCER**
☐ **FREQUENT NECK PAIN**	☐ **EMPHYSEMA/GLAUCOMA**	☐ **ANEMIA**
☐ **HIGH/LOW BLOOD PRESSURE**	☐ **PSYCHIATRIC PROBLEMS**	☐ **RHEUMATIC FEVER**
☐ **SEVERE/FREQ. HEADACHES**	☐ **KIDNEY PROBLEMS**	☐ **ULCERS/COLONITIS**
☐ **FAINTING/SEIZURE/EPILEPSY**	☐ **SINUS PROBLEMS**	☐ **ASTHMA**
☐ **DIABETES/TUBERCULOSIS**	☐ **DIFFICULTY BREATHING**	☐ **CHEMOTHERAPY**
☐ **LOWER BACK PROBLEMS**	☐ **ARTIFICIAL BONES/JOINTS**	☐ **ARTHRITIS**

Please list any other serious medical conditions that you have or have ever had. ____________________

____

Please list anything that you may be allergic to. ____________________

____

Please list previous surgeries/treatments with dates. ____________________

____

Please list any past serious accidents with dates. ____________________

____

Is there anything else about your family health history that you feel is important to share? __________

____

Do you: Take supplements or vitamins? ☐ **YES** ☐ **NO** Exercise? ☐ **YES** ☐ **NO**

Are you on a special diet? ☐ **YES** ☐ **NO** Since: ____/____/____

Do you smoke? ☐ **YES** ☐ **NO** How much? __________ How long? __________

Are you wearing: ☐ **HEEL LIFTS** ☐ **SOLE LIFTS** ☐ **INNER SOLES** ☐ **ARCH SUPPORTS** ?

What is the age of your mattress? ________ Is it comfortable? ☐ **YES** ☐ **NO**

For women: Are you taking birth control? ☐ **YES** ☐ **NO**

Are you pregnant? ☐ **YES** ☐ **NO** How long? _______ Nursing? ☐ **YES** ☐ **NO**

Patient Signature ______________________________ **Date** ________________