

**Monmouth Chiropractic Neurology Center**  
**Medical History**

**Name:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Please circle each answer as it may apply.**

**Ethnicity:** White Black Hispanic Asian Other: \_\_\_\_\_

**Do or did you smoke?** Yes No \_\_\_\_\_ pack(s)/day \_\_\_\_\_ years If quit, how long ago? (yrs.) \_\_\_\_\_

**Alcohol use:** beer wine liquor \_\_\_\_\_/drinks/day \_\_\_\_\_ don't drink **Coffee** \_\_\_\_\_/day N/A

**If female, any OBCP use?** Yes No If yes, how long? \_\_\_\_\_ How long since use? \_\_\_\_\_

**Family History**, (check all that apply): Cancer Stroke Aneurysm Diabetes Hypertension Heart disease

Other: \_\_\_\_\_

**Past Medical History**, List any previous fractures, diseases, disorders, related or unrelated: \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ High blood pressure? Yes No If yes, under control with MEDS? Yes No

**Area of complaint:** Head Eyes Neck Mid-back Lower back Vertigo Dystonia Seizure Syncope, (*Fainting*)

Other: \_\_\_\_\_

**Referring pain**, (if applicable): Head L / R Upper extremity L / R Lower extremity

**Check all that apply:** Pain Weakness Numbness Tingling Throbbing Dizziness Nausea Tearing L/R  
Anxiety Constipation Diarrhea Dizzy Imbalanced Spinning Other: \_\_\_\_\_

**Duration since onset:** Last few: Days Weeks Months Years

**Frequency:** Constant Frequent Occasional Intermittent

**Intensity:** Minimal Slight Moderate Marked

**Previous diagnostic testing, (i.e. MRI, CT, EKG, etc.):** \_\_\_\_\_

**Describe any treatment to date & outcome:** \_\_\_\_\_

**Previous doctors seen:** PCP ENT PT Cardiologist Neurologist Orthopedic Chiropractic Other: \_\_\_\_\_

**Any accidents in past 12 months?** Yes No Auto: Yes No

**Primary Care Physician:** \_\_\_\_\_

**Surgical history**, please list procedures: \_\_\_\_\_

List medications **PLEASE PRINT:** \_\_\_\_\_

**Other Comments:** \_\_\_\_\_