WARWICK VALLEY CHIROPRACTORS Dr. Nelleke Greendyk

PATIENT NAME: _____ DATE: _____

HEALTH HISTORY ADDENDUM

Please place an X in the appropriate box

| | FATHER | MOTHER | BROTHERS | SISTERS | CHILDREN |
|---|---|---|---|---|---|
| Asthma | | | | | |
| Depression | | | | | |
| Epilepsy | | | | | |
| Parkinson's | | | | | |
| Prostate Problems | | | | | |
| Other (Explain) | | | | | |
| | | | | | |

DIET RESTRICTIONS:

_____

_____

TOBACCO USE _____/DAY

ALCOHOL CONSUMPTION _____/DAY

PRESENT MEDICATIONS: Dosage and Reason:

1. _____
2. _____
3. _____
4. _____

PAST MEDICATIONS: Dosage and Reason:

1. _____
2. _____
3. _____
4. _____

CURRENT SUPPLEMENTS: Name – How much/day and Reason:

1. _____
2. _____
3. _____
4. _____

MAJOR HOSPITALIZATIONS, SURGERIES, INJURIES:

Please list all procedures, complications (if any) and dates

1. _____
2. _____
3. _____
4. _____

I certify that the information given above is true to the best of my knowledge.

_____

Patient/Parent Signature