



Name _____ Date _____

Medical History

List your four main health concerns/areas of pain or dysfunction. Please list intensity of pain or dysfunction and when it began.

1. _____

_____ Intensity 1-10 _____ Date of onset _____

2. _____

_____ Intensity 1-10 _____ Date of onset _____

3. _____

_____ Intensity 1-10 _____ Date of onset _____

4. _____

_____ Intensity 1-10 _____ Date of onset _____

List any accidents/falls experienced through childhood (include work/auto):

1. _____ Date _____

2. _____ Date _____

3. _____ Date _____

List any surgeries/medical procedures, including childhood :

1. _____ Date _____

2. _____ Date _____

3. _____ Date _____

***Do you have any surgical fusions, artificial hips/knees, implants, pacemaker, or other surgical hardware?

YES / NO Describe: _____

Dr. Jeffrey W. McCloskey, D.C.

The Health Institute of Western Colorado, 755 North Ave, Suite D, Grand Junction CO, 81501

Office: (970) 241-2400 Fax: (970) 241-3786

Please mark "C" for Current or "P" for past if you experience any of the following:

Back pain_____	Neck Pain_____	Headaches_____
Numb/Tingling Arms or Hands_____	Cancer_____	Digestive problems_____
Gas_____	Bloating_____	Diarrhea_____
Constipation_____	Urination Difficulty_____	Fatigue_____
Loss of memory_____	Dizziness_____	Hemorrhoids_____
Blood in urine, stool or semen_____	Restless Legs_____	Nightmares_____
Hot flashes_____	Breast lumps or tenderness_____	Infertility_____
Miscarriages_____	Depression_____	Mood Swings_____
Anxiety_____	Irritability_____	Chest Pain_____
Shortness of breath_____	Allergies_____	Ulcers_____
Heartburn_____	Insomnia_____	Frequent colds_____
Unexplained weight loss or gain (circle one or both)_____		Hernia_____
Menstrual Difficulties (describe) _____		

Please indicate how much weekly use of use of any of the following:

Soda_____	Diet Soda_____	Alcohol_____
Tobacco_____	Coffee_____	Caffeinated Tea_____
Sport/Energy Drinks_____	Artificial Sweeteners_____	Candy/Deserts_____

How much water (in ounces) do you drink in an average day? _____

List any previous medical diagnosis and treatments you have received for present condition:

What aggravates your health concerns?

What is your general state of health? (Circle one) Excellent Good Fair Poor

Date of last Chiropractic treatment _____ Name of Chiropractor _____

Date of last physical Exam _____ What prompted exam? _____

Date of last lab work? _____ Date of last X ray _____ What body part? _____

Name of MD/DO _____ City _____ Last Seen _____

List any medications you are currently taking:

I consent to be treated by Dr. Jeff McCloskey for the issues listed above. I understand that no medical or holistic treatment guarantees results.

Signature: _____ Date: _____