CORNERSTONE HEALTH
CHIROPRACTIC · ACUPUNCTURE · NUTRITION

Patient Name:_____ **Date of Birth**:_____ **Date**:_____

Please list current and ongoing problems in order of priority:

Problem	Severity (0-10)	Prior Treatment	Prior Treatment effectiveness
1.)			
2.)			
3.)			

Allergies to food or medications?

_____

_____

Current Medications

Medication	Dose	Frequency	Start Date (month/year)	Reason for use

Previous Medications

Medication	Dose	Frequency	Start - End Dates (months/year)	Reason for use

Nutritional Supplements

Supplement & Brand	Dose	Frequency	Start - End Dates (months/year)	Reason for use

Side Effects of any above medications or supplements?

_____

_____

Family History:

Condition	Relationship
Cancer:	
Heart Disease	
Hypertension	
Obesity	
Diabetes	
Stroke	
Arthritis (Rheumatoid, Psoriatic, Ankylosing)	
Inflammatory Bowel Disease	
Multiple Sclerosis	
Thyroid Problems	
Lupus (SLE)	
Celiac Disease	
Asthma	
Eczema/Psoriasis	
Food Allergies, sensitivities, ontolerances	
Dementia	
Parkinson's Disease	
Mental health/psychological disorders	
Autism	