



Grayhawk Family Chiropractic  
 7900 E Thompson Peak Pkwy --- #105  
 Scottsdale, AZ 85255  
 p 480.247.9063  
 f 481.247.9974  
 grayhawkchiro.medicfusion.com

Patient: \_\_\_\_\_

## Health History Form

### Prescription Medications

Prescription medications taken on a regular or ongoing basis:

Medication: _____	Dosage: _____	Frequency: per	<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Month	<input type="checkbox"/> Other	(please describe): _____
Medication: _____	Dosage: _____	Frequency: per	<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Month	<input type="checkbox"/> Other	(please describe): _____
Medication: _____	Dosage: _____	Frequency: per	<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Month	<input type="checkbox"/> Other	(please describe): _____
Medication: _____	Dosage: _____	Frequency: per	<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Month	<input type="checkbox"/> Other	(please describe): _____
Medication: _____	Dosage: _____	Frequency: per	<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Month	<input type="checkbox"/> Other	(please describe): _____
Medication: _____	Dosage: _____	Frequency: per	<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Month	<input type="checkbox"/> Other	(please describe): _____
Medication: _____	Dosage: _____	Frequency: per	<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Month	<input type="checkbox"/> Other	(please describe): _____
Medication: _____	Dosage: _____	Frequency: per	<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Month	<input type="checkbox"/> Other	(please describe): _____
Medication: _____	Dosage: _____	Frequency: per	<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Month	<input type="checkbox"/> Other	(please describe): _____
Medication: _____	Dosage: _____	Frequency: per	<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Month	<input type="checkbox"/> Other	(please describe): _____
Medication: _____	Dosage: _____	Frequency: per	<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Month	<input type="checkbox"/> Other	(please describe): _____
Medication: _____	Dosage: _____	Frequency: per	<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Month	<input type="checkbox"/> Other	(please describe): _____

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**Over-The-Counter Medications**

Over-the-counter medications taken on a regular or ongoing basis:

Medication: _____	Dosage: _____	Frequency: per	<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Month	<input type="checkbox"/> Other	(please describe): _____
Medication: _____	Dosage: _____	Frequency: per	<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Month	<input type="checkbox"/> Other	(please describe): _____
Medication: _____	Dosage: _____	Frequency: per	<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Month	<input type="checkbox"/> Other	(please describe): _____
Medication: _____	Dosage: _____	Frequency: per	<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Month	<input type="checkbox"/> Other	(please describe): _____
Medication: _____	Dosage: _____	Frequency: per	<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Month	<input type="checkbox"/> Other	(please describe): _____
Medication: _____	Dosage: _____	Frequency: per	<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Month	<input type="checkbox"/> Other	(please describe): _____
Medication: _____	Dosage: _____	Frequency: per	<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Month	<input type="checkbox"/> Other	(please describe): _____
Medication: _____	Dosage: _____	Frequency: per	<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Month	<input type="checkbox"/> Other	(please describe): _____
Medication: _____	Dosage: _____	Frequency: per	<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Month	<input type="checkbox"/> Other	(please describe): _____
Medication: _____	Dosage: _____	Frequency: per	<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Month	<input type="checkbox"/> Other	(please describe): _____
Medication: _____	Dosage: _____	Frequency: per	<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Month	<input type="checkbox"/> Other	(please describe): _____
Medication: _____	Dosage: _____	Frequency: per	<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Month	<input type="checkbox"/> Other	(please describe): _____



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### Vitamins, Minerals, Herbs, or Dietary Supplements

Vitamins, minerals, herbs, or dietary supplements taken on a regular or ongoing basis:

Supplement: _____	Dosage: _____	Frequency: per	<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Month	<input type="checkbox"/> Other
(please describe): _____						
Supplement: _____	Dosage: _____	Frequency: per	<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Month	<input type="checkbox"/> Other
(please describe): _____						
Supplement: _____	Dosage: _____	Frequency: per	<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Month	<input type="checkbox"/> Other
(please describe): _____						
Supplement: _____	Dosage: _____	Frequency: per	<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Month	<input type="checkbox"/> Other
(please describe): _____						
Supplement: _____	Dosage: _____	Frequency: per	<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Month	<input type="checkbox"/> Other
(please describe): _____						
Supplement: _____	Dosage: _____	Frequency: per	<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Month	<input type="checkbox"/> Other
(please describe): _____						
Supplement: _____	Dosage: _____	Frequency: per	<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Month	<input type="checkbox"/> Other
(please describe): _____						
Supplement: _____	Dosage: _____	Frequency: per	<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Month	<input type="checkbox"/> Other
(please describe): _____						
Supplement: _____	Dosage: _____	Frequency: per	<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Month	<input type="checkbox"/> Other
(please describe): _____						

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### Diet and Exercise

Check if you have ever smoked cigars or cigarettes.  Yes

Check if you still smoke.  Yes

How much do you smoke?  Less than one pack per week  1-2 packs per week  
 1 pack every two days  1 pack per day  More than one pack per day

Check if you drink alcoholic beverages.  Yes

How many alcoholic beverages do you consume per week? \_\_\_\_\_

Check if a physician has ever diagnosed you as an alcoholic.  Yes

Check if a physician has ever diagnosed you with any liver-related problems.  Yes

Check if you exercise regularly.  Yes

How many days do you exercise each week? \_\_\_\_\_

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## Allergies

Check if a physician has ever diagnosed you with any allergies.  Yes

Do you have Airborne allergies?  Yes

- |                                   |  |                                     |                                      |
|-----------------------------------|--|-------------------------------------|--------------------------------------|
| <input type="checkbox"/> Animal   | <input type="checkbox"/> Molds/Fungus    | <input type="checkbox"/> Pollens    | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Cat Hair | <input type="checkbox"/> Cockroach       | <input type="checkbox"/> Dog Hair   | <input type="checkbox"/> Feather Mix |
|                                   | <input type="checkbox"/> Guinea Pig Hair | <input type="checkbox"/> Dust Mites | <input type="checkbox"/> Other _____ |

Do you have Chemical allergies?  Yes

- |   |   |   |  |                                    |
|---|---|---|--|------------------------------------|
| <input type="checkbox"/> Acetone          | <input type="checkbox"/> Acetylcholine  | <input type="checkbox"/> Auto Exhaust   | <input type="checkbox"/> Benzyl Alcohol    | <input type="checkbox"/> Chlorine  |
| <input type="checkbox"/> Citric Acid      | <input type="checkbox"/> Cologne (all)  | <input type="checkbox"/> Diesel Exhaust | <input type="checkbox"/> Dopamine          | <input type="checkbox"/> Estradiol |
| <input type="checkbox"/> Ethanol          | <input type="checkbox"/> Fluorine       | <input type="checkbox"/> Formaldehyde   | <input type="checkbox"/> Latex             | <input type="checkbox"/> Melatonin |
| <input type="checkbox"/> Newspaper Print  | <input type="checkbox"/> Norepinephrine | <input type="checkbox"/> Progesterone   | <input type="checkbox"/> Propylene         | <input type="checkbox"/> Serotonin |
| <input type="checkbox"/> Silicone Implant | <input type="checkbox"/> Sponge Rubber  | <input type="checkbox"/> Toluene        | <input type="checkbox"/> Trichloroethylene | <input type="checkbox"/> Wood Pulp |
|   |   | <input type="checkbox"/> Xylene         | <input type="checkbox"/> Other _____       |                                    |

Do you have Drug allergies?  Yes

- |  |                                     |   |                                      |                                   |
|--|-------------------------------------|---|--------------------------------------|-----------------------------------|
| <input type="checkbox"/> Anticonvulsants | <input type="checkbox"/> Codeine    | <input type="checkbox"/> Insulin Preparations | <input type="checkbox"/> Iodine      | <input type="checkbox"/> Morphine |
| <input type="checkbox"/> Novocain        | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Sulfa                | <input type="checkbox"/> Other _____ |                                   |

Do you have Food allergies?  Yes

- |   |  |                                     |                                      |                                |
|---|--|-------------------------------------|--------------------------------------|--------------------------------|
| <input type="checkbox"/> Artificial Colorings | <input type="checkbox"/> Artificial Flavorings | <input type="checkbox"/> Beef       | <input type="checkbox"/> Coffee/Tea  | <input type="checkbox"/> Dairy |
| <input type="checkbox"/> Eggs                 | <input type="checkbox"/> Fish/Shellfish        | <input type="checkbox"/> Fruits     | <input type="checkbox"/> Lamb        | <input type="checkbox"/> Nuts  |
| <input type="checkbox"/> Pork                 | <input type="checkbox"/> Poultry               | <input type="checkbox"/> Vegetables | <input type="checkbox"/> Other _____ |                                |



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### Surgical History

Check if you have any implants, screws, plates or other foreign objects in your body.  Yes

- |  |  |                                      |                                      |                                      |
|--|--|--------------------------------------|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> Bullet Wound(s) | <input type="checkbox"/> Infusion Catheter | <input type="checkbox"/> Ear Implant | <input type="checkbox"/> Pacemakers  | <input type="checkbox"/> Eye Implant |
| <input type="checkbox"/> Brain Plate(s)  | <input type="checkbox"/> Heart Valve(s)    | <input type="checkbox"/> Shrapnel    | <input type="checkbox"/> Other _____ |                                      |

Musculoskeletal Surgeries (Check if you have had any of the following surgeries)

- |   |                           |                                   |                           |
|---|---------------------------|-----------------------------------|---------------------------|
| <input type="checkbox"/> Ankle                    | Year(s) of surgery: _____ | <input type="checkbox"/> Head     | Year(s) of surgery: _____ |
| <input type="checkbox"/> Back                     | Year(s) of surgery: _____ | <input type="checkbox"/> Hip      | Year(s) of surgery: _____ |
| <input type="checkbox"/> Cosmetic or Augmentation | Year(s) of surgery: _____ | <input type="checkbox"/> Knee     | Year(s) of surgery: _____ |
| <input type="checkbox"/> Elbow                    | Year(s) of surgery: _____ | <input type="checkbox"/> Neck     | Year(s) of surgery: _____ |
| <input type="checkbox"/> Foot                     | Year(s) of surgery: _____ | <input type="checkbox"/> Shoulder | Year(s) of surgery: _____ |
| <input type="checkbox"/> Hand                     | Year(s) of surgery: _____ | <input type="checkbox"/> Wrist    | Year(s) of surgery: _____ |
| <input type="checkbox"/> Other                    | Please describe: _____    |                                   | Year(s) of surgery: _____ |

Organ System Surgeries (Check if you have had any of the following surgeries)

- |   |                           |  |                           |
|---|---------------------------|--|---------------------------|
| <input type="checkbox"/> Brain            | Year(s) of surgery: _____ | <input type="checkbox"/> Intestine, large    | Year(s) of surgery: _____ |
| <input type="checkbox"/> Colon            | Year(s) of surgery: _____ | <input type="checkbox"/> Liver               | Year(s) of surgery: _____ |
| <input type="checkbox"/> Esophagus        | Year(s) of surgery: _____ | <input type="checkbox"/> Lung                | Year(s) of surgery: _____ |
| <input type="checkbox"/> Eye              | Year(s) of surgery: _____ | <input type="checkbox"/> Mastectomy          | Year(s) of surgery: _____ |
| <input type="checkbox"/> Heart            | Year(s) of surgery: _____ | <input type="checkbox"/> Reproductive Organs | Year(s) of surgery: _____ |
| <input type="checkbox"/> Kidney           | Year(s) of surgery: _____ | <input type="checkbox"/> Skin                | Year(s) of surgery: _____ |
| <input type="checkbox"/> Intestine, small | Year(s) of surgery: _____ | <input type="checkbox"/> Throat              | Year(s) of surgery: _____ |
| <input type="checkbox"/> Other            | Please describe: _____    |  | Year(s) of surgery: _____ |
| <input type="checkbox"/> Transplant       | Please describe: _____    |  | Year(s) of surgery: _____ |

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### Your Cancer History

Check if a physician has ever diagnosed you with cancer.  Yes

*Check all that apply*

- |  |  |
|--|--|
| <input type="checkbox"/> Bladder             | <input type="checkbox"/> Lung                    |
| <input type="checkbox"/> Brain               | <input type="checkbox"/> Non-Hodgkin's Lymphoma  |
| <input type="checkbox"/> Breast              | <input type="checkbox"/> Ovarian                 |
| <input type="checkbox"/> Cervical            | <input type="checkbox"/> Pancreatic              |
| <input type="checkbox"/> Colon or Rectal     | <input type="checkbox"/> Prostate                |
| <input type="checkbox"/> Endometrial         | <input type="checkbox"/> Skin                    |
| <input type="checkbox"/> Eye                 | <input type="checkbox"/> Basal Cell Carcinoma    |
| <input type="checkbox"/> Kidney (renal cell) | <input type="checkbox"/> Squamous Cell Carcinoma |
| <input type="checkbox"/> Leukemia            | <input type="checkbox"/> Melanoma                |
| <input type="checkbox"/> Other _____         | <input type="checkbox"/> Stomach                 |
|  | <input type="checkbox"/> Thyroid                 |
|  | <input type="checkbox"/> Uterine                 |

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**Family Cancer History**

Check if a physician has ever diagnosed your family with cancer.  Yes

Check all that apply and the family member(s) who had this condition:

- |  |  |
|--|--|
| <input type="checkbox"/> Bladder (M, F, S, MG, PG)             | <input type="checkbox"/> Lung (M, F, S, MG, PG)                    |
| <input type="checkbox"/> Brain (M, F, S, MG, PG)               | <input type="checkbox"/> Non-Hodgkin's Lymphoma (M, F, S, MG, PG)  |
| <input type="checkbox"/> Breast (M, F, S, MG, PG)              | <input type="checkbox"/> Ovarian (M, F, S, MG, PG)                 |
| <input type="checkbox"/> Cervical (M, F, S, MG, PG)            | <input type="checkbox"/> Pancreatic (M, F, S, MG, PG)              |
| <input type="checkbox"/> Colon or Rectal (M, F, S, MG, PG)     | <input type="checkbox"/> Prostate (M, F, S, MG, PG)                |
| <input type="checkbox"/> Endometrial (M, F, S, MG, PG)         | <input type="checkbox"/> Skin (M, F, S, MG, PG)                    |
| <input type="checkbox"/> Eye (M, F, S, MG, PG)                 | <input type="checkbox"/> Basal Cell Carcinoma (M, F, S, MG, PG)    |
| <input type="checkbox"/> Kidney (renal cell) (M, F, S, MG, PG) | <input type="checkbox"/> Squamous Cell Carcinoma (M, F, S, MG, PG) |
| <input type="checkbox"/> Leukemia (M, F, S, MG, PG)            | <input type="checkbox"/> Melanoma (M, F, S, MG, PG)                |
| <input type="checkbox"/> Other _____ (M, F, S, MG, PG)         | <input type="checkbox"/> Stomach (M, F, S, MG, PG)                 |
|  | <input type="checkbox"/> Thyroid (M, F, S, MG, PG)                 |
|  | <input type="checkbox"/> Uterine (M, F, S, MG, PG)                 |

**Family Members**

Family Members	
(M)	Mother
(F)	Father
(S)	Sibling
(MG)	Maternal Grandparent
(PG)	Paternal Grandparent

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Your Cardio-pulmonary / Circulatory Health

Check if a physician has ever diagnosed you with any of the following:

- |   |   |
|---|---|
| <input type="checkbox"/> Anemia                             | <input type="checkbox"/> HIV/AIDS                         |
| <input type="checkbox"/> Hemophilia                         | <input type="checkbox"/> Hepatitis                        |
| <input type="checkbox"/> Hypertension (high blood pressure) | <input type="checkbox"/> Hypotension (low blood pressure) |
| <input type="checkbox"/> Hemorrhoids                        | <input type="checkbox"/> Lung Disorders                   |
- |  |   |
|--|---|
| <input type="checkbox"/> Acute Respiratory Distress Syndrome       | <input type="checkbox"/> Alpha-1 Antitrypsin Deficiency   |
| <input type="checkbox"/> Asthma                                    | <input type="checkbox"/> Asbestos/Dust Disease            |
| <input type="checkbox"/> Bronchitis (chronic)                      | <input type="checkbox"/> Bronchiectasis                   |
| <input type="checkbox"/> Chronic Obstructive Pulmonary Disease     | <input type="checkbox"/> Bronchopulmonary Dysplasia (BPD) |
| <input type="checkbox"/> Farmer's Lung                             | <input type="checkbox"/> Cystic Fibrosis                  |
| <input type="checkbox"/> Histoplasmosis                            | <input type="checkbox"/> Emphysema                        |
| <input type="checkbox"/> Lymphangioleiomyomatosis                  | <input type="checkbox"/> Hantavirus                       |
| <input type="checkbox"/> Pneumonia                                 | <input type="checkbox"/> Legionellosis                    |
| <input type="checkbox"/> Primary Alveolar Hypoventilation Syndrome | <input type="checkbox"/> Pleurisy                         |
| <input type="checkbox"/> Pulmonary Fibrosis                        | <input type="checkbox"/> Pneumothorax                     |
| <input type="checkbox"/> Respiratory Syncytial Virus               | <input type="checkbox"/> Pulmonary Alveolar Proteinosis   |
| <input type="checkbox"/> Severe Acute Respiratory Syndrome         | <input type="checkbox"/> Pulmonary Embolus                |
|  | <input type="checkbox"/> Respiratory Distress Syndrome    |
|  | <input type="checkbox"/> Sarcoidosis                      |
|  | <input type="checkbox"/> Spontaneous Pneumothorax         |
|  | <input type="checkbox"/> Tuberculosis                     |
- |   |   |
|---|---|
| <input type="checkbox"/> Raynaud's Phenomenon       | <input type="checkbox"/> Sickle Cell Anemia |
| <input type="checkbox"/> Sinus Infections (chronic) | <input type="checkbox"/> Stroke             |
| <input type="checkbox"/> Wegener's Granulomatosis   | <input type="checkbox"/> Other _____        |



Family Cardio-pulmonary / Circulatory Health

Check if a physician has ever diagnosed your family with any of the following:

- Anemia (M, F, S, MG, PG)
- Hemophilia (M, F, S, MG, PG)
- Hypertension (high blood pressure) (M, F, S, MG, PG)
- Hemorrhoids (M, F, S, MG, PG)
- HIV/AIDS (M, F, S, MG, PG)
- Hepatitis (M, F, S, MG, PG)
- Hypotension (low blood pressure) (M, F, S, MG, PG)
- Lung Disorders (M, F, S, MG, PG)

<input type="checkbox"/> Acute Respiratory Distress Syndrome (M, F, S, MG, PG)	<input type="checkbox"/> Alpha-1 Antitrypsin Deficiency (M, F, S, MG, PG)
<input type="checkbox"/> Asthma (M, F, S, MG, PG)	<input type="checkbox"/> Asbestos/Dust Disease (M, F, S, MG, PG)
<input type="checkbox"/> Bronchitis (chronic) (M, F, S, MG, PG)	<input type="checkbox"/> Bronchiectasis (M, F, S, MG, PG)
<input type="checkbox"/> Chronic Obstructive Pulmonary Disease (M, F, S, MG, PG)	<input type="checkbox"/> Bronchopulmonary Dysplasia(BPD) (M, F, S, MG, PG)
<input type="checkbox"/> Farmer's Lung (M, F, S, MG, PG)	<input type="checkbox"/> Cystic Fibrosis (M, F, S, MG, PG)
<input type="checkbox"/> Histoplasmosis (M, F, S, MG, PG)	<input type="checkbox"/> Emphysema (M, F, S, MG, PG)
<input type="checkbox"/> Lymphangiomyomatosis (M, F, S, MG, PG)	<input type="checkbox"/> Hantavirus (M, F, S, MG, PG)
<input type="checkbox"/> Pneumonia (M, F, S, MG, PG)	<input type="checkbox"/> Legionellosis (M, F, S, MG, PG)
<input type="checkbox"/> Primary Alveolar Hypoventilation Syndrome (M, F, S, MG, PG)	<input type="checkbox"/> Pleurisy (M, F, S, MG, PG)
<input type="checkbox"/> Pulmonary Fibrosis (M, F, S, MG, PG)	<input type="checkbox"/> Pneumothorax (M, F, S, MG, PG)
<input type="checkbox"/> Respiratory Syncytial Virus (M, F, S, MG, PG)	<input type="checkbox"/> Pulmonary Alveolar Proteinosis (M, F, S, MG, PG)
<input type="checkbox"/> Severe Acute Respiratory Syndrome (M, F, S, MG, PG)	<input type="checkbox"/> Pulmonary Embolus (M, F, S, MG, PG)
	<input type="checkbox"/> Respiratory Distress Syndrome (M, F, S, MG, PG)
	<input type="checkbox"/> Sarcoidosis (M, F, S, MG, PG)
	<input type="checkbox"/> Spontaneous Pneumothorax (M, F, S, MG, PG)
	<input type="checkbox"/> Tuberculosis (M, F, S, MG, PG)

- Raynaud's Phenomenon (M, F, S, MG, PG)
- Sinus Infections (chronic) (M, F, S, MG, PG)
- Wegener's Granulomatosis (M, F, S, MG, PG)
- Sickle Cell Anemia (M, F, S, MG, PG)
- Stroke (M, F, S, MG, PG)
- Other \_\_\_\_\_ (M, F, S, MG, PG)

Family Members	
(M)	Mother
(F)	Father
(S)	Sibling
(MG)	Maternal Grandparent
(PG)	Paternal Grandparent



Endocrine, Gastrointestinal and Neurologic Health

Check if a physician has ever diagnosed you with any of the following:

Autoimmune Disorder

<input type="checkbox"/> Dermatitis	<input type="checkbox"/> Churg-Strauss (Allergic Granulomatosis)
<input type="checkbox"/> Eosinophilic Fasciitis	<input type="checkbox"/> Dermatomyositis/Polymyositis
<input type="checkbox"/> Goodpasture's Syndrome	<input type="checkbox"/> Interstitial Granulomatous Dermatitis
<input type="checkbox"/> Lupus	with Arthritis
<input type="checkbox"/> Lupus SLE	
<input type="checkbox"/> Lupus DLE	
<input type="checkbox"/> Lupus SCLE	
<input type="checkbox"/> Anti-Phospholipid Antibody Syndrome (Lupus Anticoagulant)	
<input type="checkbox"/> Mixed Connective Tissue Disease	<input type="checkbox"/> Relapsing Polychondritis
<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Sarcoidosis
<input type="checkbox"/> Scleroderma	<input type="checkbox"/> Sjogren's Syndrome
<input type="checkbox"/> Skin Immunofluorescence	<input type="checkbox"/> Vasculitis

Bladder Disease

Candida

Chicken Pox

Chronic Fatigue Syndrome

Crohn's Disease

Diabetes

Epilepsy

Fibromyalgia

Gall Bladder Problems

Headaches

Cluster Headaches

Migraine Headaches

Sinus Headaches

Stress-induced Headaches

Tension Headaches

Incontinence

Irritable Bowel Syndrome (IBS)

Kidney Disease

Liver Disease

Liver Problems

Measles

Mumps

Seizures

Shingles

Stomach Ulcers

Thyroid Dysfunction

Urinary Tract Infection

Other \_\_\_\_\_



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### Emotional and Mental Health

Check if a physician has ever diagnosed you with an emotional or mental condition.  Yes

- |  |   |
|--|---|
| <input type="checkbox"/> Anger Disorders                                   | <input type="checkbox"/> Anxiety Disorders                                    |
| <input type="checkbox"/> Asperger Syndrome                                 | <input type="checkbox"/> Attention Deficit Disorder with Hyperactivity (ADHD) |
| <input type="checkbox"/> Autistic Disorder                                 | <input type="checkbox"/> Avoidant Personality Disorder (AvPD)                 |
| <input type="checkbox"/> Bipolar Disorder                                  | <input type="checkbox"/> Borderline Personality Disorder                      |
| <input type="checkbox"/> Capgras Syndrome                                  | <input type="checkbox"/> Child Behavior Disorders                             |
| <input type="checkbox"/> Combat Disorders                                  | <input type="checkbox"/> Cyclothymic Disorder                                 |
| <input type="checkbox"/> Dependent Personality Disorder (DPD)              | <input type="checkbox"/> Depressive Disorders (depression)                    |
| <input type="checkbox"/> Dissociative Disorders                            | <input type="checkbox"/> Dysthymic Disorders (mood disorder)                  |
| <input type="checkbox"/> Eating Disorders                                  | <input type="checkbox"/> Firesetting Behavior                                 |
| <input type="checkbox"/> Hypochondriasis (Somatoform Disorder)             | <input type="checkbox"/> Impulse Control Disorders                            |
| <input type="checkbox"/> Kleptomania                                       | <input type="checkbox"/> Kleine-Levin Syndrome                                |
| <input type="checkbox"/> Munchausen Syndrome                               | <input type="checkbox"/> Multiple Personality Disorder                        |
| <input type="checkbox"/> Narcolepsy  | <input type="checkbox"/> Narcissistic Personality Disorder                    |
| <input type="checkbox"/> Phobic Disorders (Phobias)                        | <input type="checkbox"/> Obsessive Compulsive Disorder (OCD)                  |
| <input type="checkbox"/> Restless Legs Syndrome                            | <input type="checkbox"/> Psychotic Disorders                                  |
| <input type="checkbox"/> Seasonal Affective Disorder                       | <input type="checkbox"/> Schizophrenia  |
| <input type="checkbox"/> Sexual Dysfunctions (psychological, not physical) | <input type="checkbox"/> Sexual or Gender Disorders                           |
| <input type="checkbox"/> Substance Abuse                                   | <input type="checkbox"/> Sleep Disorders                                      |
| <input type="checkbox"/> Other _____                                       | <input type="checkbox"/> Post-traumatic Stress Syndrome                       |
|  | <input type="checkbox"/> Suicidal Tendencies                                  |

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### Sensory Health

Check if a physician has ever diagnosed you with any of the following:

- |   |  |
|---|--|
| <input type="checkbox"/> Blindness            | <input type="checkbox"/> Cataract                  |
| <input type="checkbox"/> Cholesteatoma        | <input type="checkbox"/> Deafness or Hearing Loss  |
| <input type="checkbox"/> Ear ringing          | <input type="checkbox"/> Eczema                    |
| <input type="checkbox"/> Glaucoma             | <input type="checkbox"/> Laryngitis (chronic)      |
| <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Mumps                     |
| <input type="checkbox"/> Meniere's Disease    | <input type="checkbox"/> Nasal Polyps              |
| <input type="checkbox"/> Perforated Eardrum   | <input type="checkbox"/> Psoriasis                 |
| <input type="checkbox"/> Rhinitis             | <input type="checkbox"/> Sinusitis                 |
| <input type="checkbox"/> Tinnitus             | <input type="checkbox"/> Unusual Vision Impairment |
| <input type="checkbox"/> Vertigo              | <input type="checkbox"/> Other _____               |

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### Musculoskeletal Health

Check if a physician has ever diagnosed you with any of the following:

Arthritis

- |   |  |
|---|--|
| <input type="checkbox"/> Ankylosing Spondylitis                 | <input type="checkbox"/> Behets Disease                                  |
| <input type="checkbox"/> Carpal Tunnel Syndrome                 | <input type="checkbox"/> Diffuse Idiopathic Skeletal Hyperostosis (DISH) |
| <input type="checkbox"/> Ehlers-Danlos Syndrome (EDS)           | <input type="checkbox"/> Felty's Syndrome                                |
| <input type="checkbox"/> Fibromyalgia                           | <input type="checkbox"/> Infectious Arthritis                            |
| <input type="checkbox"/> Mixed Connective Tissue Disease (MCTD) | <input type="checkbox"/> Osteoarthritis                                  |
| <input type="checkbox"/> Paget's Disease                        | <input type="checkbox"/> Osteoporosis                                    |
| <input type="checkbox"/> Polymyositis and Dermatomyositis       | <input type="checkbox"/> Polymyalgia Rheumatica                          |
| <input type="checkbox"/> Reactive Arthritis                     | <input type="checkbox"/> Pseudogout                                      |
| <input type="checkbox"/> Rheumatoid Arthritis                   | <input type="checkbox"/> Psoriatic Arthritis                             |
| <input type="checkbox"/> Sjogren's Syndrome                     | <input type="checkbox"/> Repetitive Stress Injury                        |
|   | <input type="checkbox"/> Scleroderma                                     |
|   | <input type="checkbox"/> Stills Disease                                  |

- |  |   |
|--|---|
| <input type="checkbox"/> Gout                          | <input type="checkbox"/> Herniated Disk                         |
| <input type="checkbox"/> Lyme Disease                  | <input type="checkbox"/> Multiple Sclerosis                     |
| <input type="checkbox"/> Muscular Dystrophy            | <input type="checkbox"/> Numbness or Tingling in feet           |
| <input type="checkbox"/> Numbness or Tingling in hands | <input type="checkbox"/> Osteoporosis                           |
| <input type="checkbox"/> Parkinson's Disease           | <input type="checkbox"/> Pinched Nerve                          |
| <input type="checkbox"/> Polio                         | <input type="checkbox"/> Rheumatism                             |
| <input type="checkbox"/> Sciatica                      | <input type="checkbox"/> Temporomandibular Joint Syndrome (TMJ) |
| <input type="checkbox"/> Other _____                   |   |

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### Reproductive Health

Check if you have ever given birth.  Yes

How many births vaginally? \_\_\_\_\_

How many births by C-section? \_\_\_\_\_

Check if a physician has ever diagnosed you with any of the following:

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> Chlamydia              | <input type="checkbox"/> Dysplasia                  | <input type="checkbox"/> Erectile Dysfunction               | <input type="checkbox"/> Genital Herpes       |
| <input type="checkbox"/> Gonorrhea              | <input type="checkbox"/> Human Papillomavirus (HPV) | <input type="checkbox"/> Impotency                          | <input type="checkbox"/> Syphilis             |
| <input type="checkbox"/> Infertility            | <input type="checkbox"/> Cystitis                   | <input type="checkbox"/> Menopause                          | <input type="checkbox"/> Prostate Enlargement |
| <input type="checkbox"/> Testicular Dysfunction | <input type="checkbox"/> Uterine Fibroid            | <input type="checkbox"/> Vaginal Yeast Infections (chronic) | <input type="checkbox"/> Other _____          |

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Patient: \_\_\_\_\_

## Chief Complaint Form

### Chief Complaint

Case Title: \_\_\_\_\_

Describe the reason for your visit: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

When did your symptoms begin? (select one)

- Today                                       This week                                       Within last 3 months  
 3 months to 6 months                       6 months to one year                       More than one year

For Women Only: Most recent menstrual cycle: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Are you pregnant?                       Yes                       No

Which word describes the frequency of your discomfort? (select one)

- Constant                       Intermittent                       Occasional                       Rare

Which phrases best describe *changes* in your discomfort during the day? (select one or more)

- It is worse in the morning                       It is worse in the afternoon                       It is worse at night  
 It changes with the weather                       It does not change

What helps *relieve* your discomfort? (select one or more)

- Ice                       Heat                       Medication                       Other (please describe) \_\_\_\_\_

What activities are limited by your discomfort? (select one or more)

- Bending                       Bowel Movements                       Coughing                       Daily Routine  
 Driving                       Getting Up                       Lifting                       Lying Down  
 Pulling                       Pushing                       Reading                       Sitting  
 Sleeping                       Sneezing                       Standing                       Turning my head  
 Urination                       Walking                       Working                       Other (please describe) \_\_\_\_\_

Where applicable, specify the approximate date of your most recent: (month / year)

Physical Exam: \_\_\_\_\_ / \_\_\_\_\_                      Dental X-rays: \_\_\_\_\_ / \_\_\_\_\_  
 Spinal X-ray: \_\_\_\_\_ / \_\_\_\_\_                      CT Scan: \_\_\_\_\_ / \_\_\_\_\_  
 MRI: \_\_\_\_\_ / \_\_\_\_\_                      Other Scans or X-rays: \_\_\_\_\_ / \_\_\_\_\_

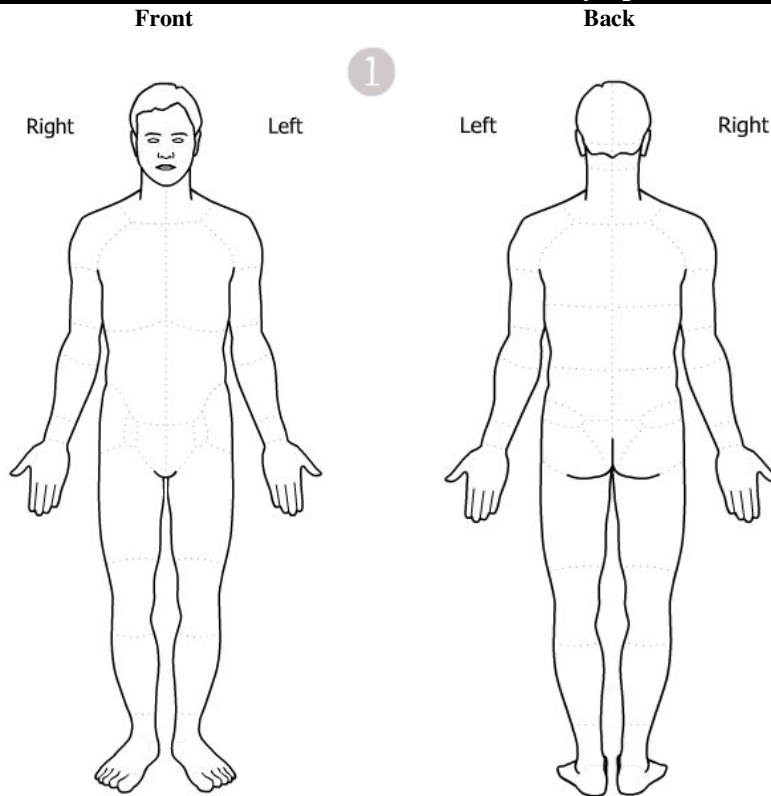
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Patient: \_\_\_\_\_

## Patient Symptom Illustrator

### Patient Symptom Illustrator



#### Instructions:

- 1 Identify your areas of discomfort by marking the affected body parts in the illustration.
- 2 Indicate the area name along with your specific symptoms associated with each selected area.
- 3 Rate your discomfort associated with each selected area.

2

		Burning	Dull Ache	Sharp Stabbing	Throbbing	Numbness	Pins and Needles	Spasm	Swelling	Stiffness	
Ex.	L (R) Lower Back			X			X			X	0 1 2 3 4 5 6 7 8 9 10
1.	L R										0 1 2 3 4 5 6 7 8 9 10
2.	L R										0 1 2 3 4 5 6 7 8 9 10
3.	L R										0 1 2 3 4 5 6 7 8 9 10
4.	L R										0 1 2 3 4 5 6 7 8 9 10

3

0 = No Discomfort 10 = Severe Discomfort