

NAME _____

DATE OF BIRTH _____

PLEASE BRIEFLY DESCRIBE THE CONDITION THAT YOU ARE HERE FOR TODAY: _____

_____ DATE _____

IS CURRENT INJURY DUE TO AN AUTO ACCIDENT? YES NO IS CURRENT INJURY DUE TO A WORK RELATED ACCIDENT? YES NO

DO YOUR CURRENT INJURIES AFFECT THE NUMBER OF HOURS YOU CAN WORK? YES NO

ARE YOU CURRENTLY SUFFERING FROM ANY OF THE SYMPTOMS LISTED BELOW?

NONE OF THE SYMPTOMS LISTED BELOW

GENERAL SYMPTOMS

- FATIGUE
- WEAKNESS
- FEVER
- LOSS OF SLEEP
- CHILLS
- UNPLANNED WEIGHT CHANGE
- NIGHT SWEATS
- HEADACHES
- DIZZINESS
- FAINTING

MENTAL HEALTH

- CONVULSIONS
- NERVOUSNESS
- ANXIETY
- DEPRESSION
- PHOBIAS
- MEMORY LOSS
- MOOD SWINGS

SENSES

- HEARING TROUBLE
- RINGING IN EARS
- PAIN IN EARS
- EYE DISCHARGE
- VISION TROUBLE
- PAIN IN EYES
- ~~EYE DISCHARGE~~
- NOSE OR SINUS PAIN

- EXCESSIVE SINUS DRAINAGE
- NOSEBLEEDS
- NASAL INFECTIONS
- ABSENCE OF SMELL
- MOUTH SORES
- BLEEDING GUMS
- ENLARGED GLANDS
- ABSENCE OF TASTE
- ABNORMAL TASTE SENSATION
- SORE THROAT
- DIFFICULTY SWALLOWING

METABOLISM & ENDOCRINE SYSTEM

- HEAT/COLD INTOLERANCE
- GOITER
- TREMOR/SHAKING
- SKIN RASH
- REDNESS OF SKIN
- SKIN DRYNESS
- ECZEMA
- HAIR LOSS
- CHANGES IN NAILS
- BRUISE EASILY

CARDIOPULMONARY

- CHRONIC COUGH
- CHRONIC WHEEZING
- SWOLLEN FEET/HANDS
- BLUE FINGERS/TOES
- DIFFICULTY BREATHING
- VARICOSE VEINS
- RAPID HEART BEAT

- CHEST PAINS
- HEART PALPITATIONS
- HEART MURMUR

DIGESTIVE

- DECREASED OR INCREASED APPETITE
- ABDOMINAL PAIN
- HEMORRHOIDS
- EXCESSIVE GAS
- VOMITING
- DIARRHEA
- CONSTIPATION
- HEARTBURN/INDIGESTION

GENITOURINARY

- PAINFUL URINATION
- INABILITY TO HOLD URINE
- FREQUENT URINATION
- BED-WETTING
- STERILITY
- IMPOTENCE

WOMENS' HEALTH

- IRREGULAR MENSTRUATION
- HOT FLASHES
- PAINFUL MENSTRUATION
- ABNORMAL VAGINAL BLEEDING
- LUMPS IN BREAST
- REDNESS OR ITCHING OF BREASTS
- DIMPLING OF BREASTS
- DISCHARGE FROM BREASTS
- BREAST PAIN

PLEASE INDICATE IF YOU NOW HAVE OR HAVE HAD ANY OF THE FOLLOWING ILLNESSES.

NOW HAVE IN PAST

- NONE OF THE LISTED CONDITIONS
- SINUS TROUBLE
- HAY FEVER
- ALLERGIES
- ASTHMA
- EMPHYSEMA
- TUBERCULOSIS
- CANCER
- DIABETES (TYPE I OR TYPE II)
- EPILEPSY
- THYROID TROUBLE

NOW HAVE IN PAST

- HIGH BLOOD PRESSURE
- LOW BLOOD PRESSURE
- HEART TROUBLE
- PACE MAKER
- STROKE
- AORTIC ANEURYSM
- ANEMIA
- RHEUMATIC FEVER
- POLIO
- MULTIPLE SCLEROSIS
- ULCER

NOW HAVE IN PAST

- LIVER TROUBLE
- KIDNEY TROUBLE
- PROSTATE TROUBLE
- ARTHRITIS
- SCOLIOSIS
- DISLOCATION OF A JOINT
- SPINAL DISC DISEASE
- MENTAL/EMOTIONAL DIFFICULTIES
- SEXUALLY TRANSMITTED DISEASE
- HIV, AIDS OR ARC
- OTHER

NAME _____ DATE OF BIRTH _____

ADDRESS _____ CITY _____ ZIPCODE _____

CELL PHONE (____) _____ MARRIED SINGLE WIDOWED DIVORCED

DAYTIME PHONE (____) _____ BESIDES YOURSELF, HOW MANY ADULTS LIVE IN YOUR HOME? _____

NIGHTTIME PHONE (____) _____ HOW MANY CHILDREN LIVE IN YOUR HOME? _____

EMAIL _____

EMPLOYER _____ OCCUPATION _____

IN CASE OF EMERGENCY, CONTACT _____ (____) _____

WHO REFERRED YOU TO OUR OFFICE? _____

1. WOMEN

- ARE YOU PREGNANT? YES NO
- HOW MANY FULL TERM PREGNANCIES _____

2. ARE YOU CURRENTLY TAKING ANY MEDICATION

MEDICATIONS

3. LIST ALL SURGERY

DATE REASON

DATE	REASON

4. LIST ALL SERIOUS ACCIDENTS, INJURIES OR FRACTURES

DATE REASON

DATE	REASON

5. LIST ANY HOSPITALIZATIONS

DATE REASON

DATE	REASON

6. ARE YOU ALLERGIC TO ANY MEDICATION

MEDICATION

HAVE YOU EVER BEEN UNDER CHIROPRACTIC CARE? YES NO DR's NAME _____

DO YOU HAVE A GENERAL MEDICAL OR OSTEOPATHIC PHYSICIAN YES NO DR's NAME _____

DO YOU NOW TAKE VITAMINS OR MINERALS? YES NO DO YOU THINK YOU MAY NEED VITAMINS OR MINERALS YES NO

ARE YOU WEARING FOOT ORTHOTICS? YES NO DO YOU HAVE A LIFT IN ONE SHOE? YES NO

DID YOU PLAY SPORTS IN SCHOOL? YES NO WHAT SPORTS? _____

WHAT DO YOU DO FOR PHYSICAL ACTIVITY? _____

RIGHT HANDED LEFT HANDED

DO YOU SMOKE? USED TO YES NO HOW MANY ALCOHOLIC BEVERAGES DO YOU HAVE IN A WEEK? _____

SIGNATURE _____ DATE _____