Have you ever been to a chiropractor before? ____No ____Yes (name):_____

List previous treatments you have received for this present condition:_____

Do you smoke? ____No ____Yes **Do you exercise?** ____No ____Yes (activities):_____

Rate your sleep, hours per night: < 4 4 – 6 6 – 8 8 – 10 12+

Rate your diet: Poor Fair Medium Good Excellent

Please list all medications you are currently taking:_____

Please list any surgeries and operations:_____

Please list any family medical conditions: (Ie. Diabetes, Stroke, High Blood Pressure, Cancer, Heart Disease)

_____

Please review carefully, and indicate if you have experienced any of the following symptoms.

P = PREVIOUS O = OCCASIONAL F = FREQUENT

GENERAL
____ chills
____ convulsions
____ dizziness
____ fainting
____ fevers
____ headaches
____ loss of sleep
____ nervousness
____ depression
____ neuralgia
____ numbness
____ sweats
____ loss of weight
____ tremors
____ allergy

MUSCLE & JOINT
____ bursitis
____ foot trouble
____ hernia
____ low back pain
____ neck stiffness / pain
____ arthritis
____ swollen joints

RESPIRATORY
____ chest pain
____ chronic cough
____ difficulty breathing
____ spitting blood
____ throat phlegm
____ wheezing

EYES, EARS, NOSE & THROAT
____ crossed eyes
____ deafness
____ dental decay
____ asthma
____ ear aches
____ ear discharges
____ ear ringing
____ sinus infections
____ enlarged glands
____ enlarged thyroid
____ sore throats
____ tonsillitis
____ eye pain
____ failing vision
____ far sighted
____ near sighted
____ colds
____ hay fever
____ hoarseness
____ nasal obstruction
____ nosebleeds

CARDIO-VASCULAR
____ rapid heart beats
____ slow heart beat
____ swelling of ankles
____ hardening of arteries
____ high blood pressure
____ low blood pressure
____ pain over heart
____ poor circulation

SKIN
____ bruise easily
____ dryness
____ hives or allergy
____ itching
____ skin rash
____ varicose veins
____ boils

GENITO-URINARY
____ blood in urine
____ frequent urination
____ loss control urine
____ kidney infection
____ painful urination
____ prostate trouble
____ puss in urine
____ odd smell of urine
____ bed wetting

PAIN OR NUMBNESS IN:
____ arms
____ hands
____ hips
____ legs
____ knees
____ ankles
____ feet
____ painful tail bone
____ sciatica
____ shoulders

GASTRO INTESTINAL
____ excessive hunger
____ burping or gas
____ liver trouble
____ colitis
____ colon trouble
____ constipation
____ diarrhea
____ difficult digestion
____ distended abdomen
____ stomach pain
____ gall bladder trouble
____ hemorrhoids
____ intestinal worms
____ jaundice
____ poor appetite
____ nausea
____ vomiting
____ vomit blood

FOR WOMEN ONLY
____ cramps
____ heavy flow
____ light flow
____ irregular cycle
____ painful cycle
____ discharge
____ sore breasts
Menopausal: Yes or No
Last Menstruation Date:
_____
Pregnant: Yes or No
Due Date:_____

FEE STRUCTURE: It is expected that payment will be made at each office visit or, if you prefer, you may pay in advance. There is a charge for missed appointments if 24 hours notice is not given.

_____ _____ _____

Signature of patient, parent or guardian Witness Date