Please check the correct box for each item below. Check at least one box for each sign or symptom listed. ❑ Never ❑ Previously ❑ Presently.

Never	Previously	Presently	GENERAL SYMPTOMS		
❑	❑	❑	995.3	Allergy (What)___	
❑	❑	❑	490	Bronchitis	
❑	❑	❑	780.9	Chills	
❑	❑	❑	780.39	Convulsions	
❑	❑	❑	780.4	Dizziness	
❑	❑	❑	780.2	Fainting	
❑	❑	❑	780.79	Fatigue	
❑	❑	❑	780.6	Fever	
❑	❑	❑	784.0	Headache	
❑	❑	❑	780.52	Loss of Sleep	
❑	❑	❑	783	Loss of Weight	
❑	❑	❑	799.2	Nervousness	
❑	❑	❑	729.2	Neuralgia	
❑	❑	❑	780.8	Sweats	
❑	❑	❑	786.07	Wheezing	
❑	❑	❑	311	Depression	

Never	Previously	Presently	GASTRO-INTESTINAL	
❑	❑	❑	787.3	Belching/Gas/Bloating
❑	❑	❑	789.0	Abdominal Pain
❑	❑	❑	564.0	Constipation
❑	❑	❑	787.91	Diarrhea
❑	❑	❑	783.6	Excessive Eating
❑	❑	❑	575.9	Gall Bladder Trouble
❑	❑	❑	455	Hemorrhoids (piles)
❑	❑	❑	782.4	Jaundice
❑	❑	❑	794.8	Liver Trouble
❑	❑	❑	787.02	Nausea
❑	❑	❑	536.9	Stomach Pain
❑	❑	❑	783.0	Poor Appetite
❑	❑	❑	536.8	Poor Digestion
❑	❑	❑	787.03	Vomiting
❑	❑	❑	578.0	Vomiting Blood
❑	❑	❑	783.5	Excessive Thirst
❑	❑	❑	536.8	Indigestion
❑	❑	❑	569.3	Rectal Bleeding

Never	Previously	Presently	EYE/EAR/NOISE/THROAT	
❑	❑	❑	493.9	Asthma
❑	❑	❑	378.9	Crossed Eyes
❑	❑	❑	389.9	Deafness
❑	❑	❑	388.70	Earache
❑	❑	❑	388.60	Ear Discharge
❑	❑	❑	388.30	Ear Noises
❑	❑	❑	240.9	Enlarged Thyroid
❑	❑	❑	460	Frequent Colds
❑	❑	❑	477	Hay Fever
❑	❑	❑	784.49	Hoarseness
❑	❑	❑	478.1	Nasal Obstruction
❑	❑	❑	784.7	Nosebleeds
❑	❑	❑	379.91	Pain in Eyes
❑	❑	❑	368.9	Poor Vision
❑	❑	❑	461.9	Sinusitis
❑	❑	❑	462	Sore Throat
❑	❑	❑	463	Tonsillitis
❑	❑	❑	786.2	Persistent Cough
❑	❑	❑	787.2	Difficulty Swallowing
❑	❑	❑	523.8	Bleeding Gums

Never	Previously	Presently	RESPIRATORY	
❑	❑	❑	786.50	Chest Pain
❑	❑	❑	786.2	Chronic Cough
❑	❑	❑	786.09	Difficulty Breathing
❑	❑	❑	786.3	Spitting Blood
❑	❑	❑	786.4	Spitting Phlegm

GENITO-URINARY

❑ ❑ ❑	788.36	Bed Wetting
❑ ❑ ❑	599.7	Blood in Urine
❑ ❑ ❑	788.4	Frequent Urination
❑ ❑ ❑	788.3	Lack of Bladder Control
❑ ❑ ❑	590.9	Kidney Infection
❑ ❑ ❑	788.1	Painful Urination
❑ ❑ ❑	601.9	Prostate Trouble

MUSCLES/JOINTS/BONES

❑ ❑ ❑	724.5	Backache
❑ ❑ ❑	719.7	Foot Trouble
❑ ❑ ❑	550	Hernia
❑ ❑ ❑	719.1	Pain Between Shoulders
❑ ❑ ❑	724.6	Painful Tail Bone
❑ ❑ ❑	723.9	Stiff Neck
❑ ❑ ❑	781.9	Spinal Curvature
❑ ❑ ❑	719.0	Swollen Joints
❑ ❑ ❑	781.0	Tremors/Twitching
❑ ❑ ❑	782	Arm Trouble

CARDIO-VASCULAR

❑ ❑ ❑	401.9	High Blood Pressure
❑ ❑ ❑	458.9	Low Blood Pressure
❑ ❑ ❑	786.51	Pain Over Heart
❑ ❑ ❑	785.9	Poor Circulation
❑ ❑ ❑	438	Previous Heart Trouble
❑ ❑ ❑	785.0	Rapid Heart
❑ ❑ ❑	427.89	Slow Heart
❑ ❑ ❑	436	Strokes
❑ ❑ ❑	719.7	Swelling Ankles
❑ ❑ ❑	454	Varicose Veins

SKIN OR ALLERGIES

❑ ❑ ❑	680.9	Boils
❑ ❑ ❑	924.9	Bruising Easily
❑ ❑ ❑	701.1	Dryness
❑ ❑ ❑	691.8	Eczema
❑ ❑ ❑	708.9	Hives or Allergy
❑ ❑ ❑	698.9	Itching
❑ ❑ ❑	782.0	Sensitive Skin
❑ ❑ ❑	782.1	Skin Eruptions

FOR WOMEN ONLY

❑ ❑ ❑	625.3	Cramps or Backaches
❑ ❑ ❑	626.2	Excessive Flow
❑ ❑ ❑	627.2	Hot Flashes
❑ ❑ ❑	626.4	Irregular Cycle
❑ ❑ ❑	634.9	Miscarriage
❑ ❑ ❑	625.3	Painful Periods
❑ ❑ ❑	623.5	Vaginal Discharge
❑ ❑ ❑	611.79	Lump in Breast
❑ Yes ❑ No		Pregnant at this time?
❑ Yes ❑ No		Have you had a mammogram?
_____		Last Pap Date
_____		By Whom

OPERATIONS AND PROCEDURES

DATE		DATE		DATE	
_____	Vaccinations	_____	Tubes in Ears	_____	Sinus
_____	Tonsillectomy	_____	Appendectomy	_____	Hernia
_____	Gall Bladder	_____	Female Organs	_____	Thyroid
_____	Back Operation	_____	Rectal Surgery	_____	Stomach
_____	Other: _____	_____	Other: _____	_____	Other: _____

❑ I have never had any operations / surgeries

List any accidents or falls and dates: ❑ Car:_____ ❑ Recreation: _____
❑ Sports:_____ ❑ School:_____ ❑ Other: _____
List any broken bones (fractures) or dislocations:_____
Ever on crutches? ❑ Yes ❑ No Why?_____
Have you ever had any spinal taps or spinal injections? ❑ Yes ❑ No Were you ever knocked unconscious? ❑ Yes ❑ No
Have you ever had a lapse of memory? ❑ Yes ❑ No
Have you ever had X-rays taken? ❑ Yes ❑ No When?_____ By Whom? _____
For what ailments were these X-rays made? _____
Do you suffer from any condition other than that for which you are now consulting us? _____
Are you presently taking any medication - prescription or over-the -counter? ❑ Yes ❑ No What drugs? _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection form the in insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to examine and treat my condition as he/she deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed the amount paid the Doctor for X-rays is for examination only and the X-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

Patient's/Guardian's Signature: X_____ Date:_____