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

## GENERAL SYMPTOMS

| Never | Previously | Presently | | |
|---|---|---|---|---|
| ❑ | ❑ | ❑ | 995.3 | Allergy (What) _____ |
| ❑ | ❑ | ❑ | 491 | Bronchitis |
| ❑ | ❑ | ❑ | 780.9 | Chills |
| ❑ | ❑ | ❑ | 780.3 | Convulsions |
| ❑ | ❑ | ❑ | 780.4 | Dizziness |
| ❑ | ❑ | ❑ | 780.2 | Fainting |
| ❑ | ❑ | ❑ | 780.7 | Fatigue |
| ❑ | ❑ | ❑ | 780.6 | Fever |
| ❑ | ❑ | ❑ | 784.0 | Headache |
| ❑ | ❑ | ❑ | 780.52 | Loss of Sleep |
| ❑ | ❑ | ❑ | 783 | Loss of Weight |
| ❑ | ❑ | ❑ | 799.2 | Nervousness |
| ❑ | ❑ | ❑ | 729.2 | Neuralgia |
| ❑ | ❑ | ❑ | 780.8 | Night Sweats |
| ❑ | ❑ | ❑ | 782 | Numbness or pain in arms/legs/hands |
| ❑ | ❑ | ❑ | 786.09 | Wheezing |

## MUSCLES & JOINTS

| | | | | |
|---|---|---|---|---|
| ❑ | ❑ | ❑ | 724.5 | Backache |
| ❑ | ❑ | ❑ | 719.7 | Foot Trouble |
| ❑ | ❑ | ❑ | 550.0 | 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 |
| ❑ | ❑ | ❑ | 781.0 | Twitching |
| ❑ | ❑ | ❑ | 728.8 | Weakness |

## GASTRO-INTESTINAL

| Never | Previously | Presently | | |
|---|---|---|---|---|
| ❑ | ❑ | ❑ | 787.3 | Belching or Gas |
| ❑ | ❑ | ❑ | 789.0 | Colon Trouble |
| ❑ | ❑ | ❑ | 564.0 | Constipation |
| ❑ | ❑ | ❑ | 558.9 | Diarrhea |
| ❑ | ❑ | ❑ | 783.6 | Excessive Hunger |
| ❑ | ❑ | ❑ | 575.9 | Gall Bladder Trouble |
| ❑ | ❑ | ❑ | 455.6 | Hemorrhoids (Piles) |
| ❑ | ❑ | ❑ | 782.4 | Jaundice |
| ❑ | ❑ | ❑ | 794.8 | Liver Trouble |
| ❑ | ❑ | ❑ | 787.0 | Nausea |
| ❑ | ❑ | ❑ | 536.8 | Pain over Stomach |
| ❑ | ❑ | ❑ | 783.0 | Poor Appetite |
| ❑ | ❑ | ❑ | 536.8 | Poor Digestion |
| ❑ | ❑ | ❑ | 787.0 | Vomiting |
| ❑ | ❑ | ❑ | 578.0 | Vomiting Blood |

## 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 |
| ❑ | ❑ | ❑ | 782.3 | Swelling Ankles |
| ❑ | ❑ | ❑ | 454 | Varicose Veins |

## EYE/EAR/NOSE/THROAT

| Never | Previously | Presently | | |
|---|---|---|---|---|
| ❑ | ❑ | ❑ | 493.9 | Asthma |
| ❑ | ❑ | ❑ | 378.9 | Crossed Eyes |
| ❑ | ❑ | ❑ | 389.9 | Deafness |
| ❑ | ❑ | ❑ | 388.70 | Earache |
| ❑ | ❑ | ❑ | 388.60 | Ear Discharges |
| ❑ | ❑ | ❑ | 388.30 | Ear Noises |
| ❑ | ❑ | ❑ | 240.9 | Enlarged Thyroid |
| ❑ | ❑ | ❑ | 460 | Frequent Colds |
| ❑ | ❑ | ❑ | 477.9 | Hay Fever |
| ❑ | ❑ | ❑ | 784.49 | Hoarseness |
| ❑ | ❑ | ❑ | 478.1 | Nasal Obstruction |
| ❑ | ❑ | ❑ | 784.7 | Nose Bleeds |
| ❑ | ❑ | ❑ | 379.91 | Pain in Eyes |
| ❑ | ❑ | ❑ | 368.9 | Poor Vision |
| ❑ | ❑ | ❑ | 473.9 | Sinusitis |
| ❑ | ❑ | ❑ | 462 | Sore Throats |
| ❑ | ❑ | ❑ | 463 | Tonsillitis |

## SKIN OR ALLERGIES

| | | | | |
|---|---|---|---|---|
| ❑ | ❑ | ❑ | 690 | Boils |
| ❑ | ❑ | ❑ | 924.9 | Bruising Easily |
| ❑ | ❑ | ❑ | 701.1 | Drynes |
| ❑ | ❑ | ❑ | 691.8 | Eczema |
| ❑ | ❑ | ❑ | 708.9 | Hives or Allergy |
| ❑ | ❑ | ❑ | 698.9 | Itching |
| ❑ | ❑ | ❑ | 782.0 | Sensitive Skin |
| ❑ | ❑ | ❑ | 368.9 | Skin Eruptions |

## RESPIRATORY

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

## GENITO-URINARY

| | | | | |
|---|---|---|---|---|
| ❑ | ❑ | ❑ | 788.3 | Bed Wetting |
| ❑ | ❑ | ❑ | 599.7 | Blood in Urine |
| ❑ | ❑ | ❑ | 788.4 | Frequent Urination |
| ❑ | ❑ | ❑ | 788.3 | Inability to Control Urine |
| ❑ | ❑ | ❑ | 590.9 | Kidney Infection |
| ❑ | ❑ | ❑ | 788.1 | Painful Urination |
| ❑ | ❑ | ❑ | 601.9 | Prostate Trouble |

## 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 |

❑ No ❑ Pregnant at this Time

_____ 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_____ ❑ Recreational Vehicle _____

❑ Sports_____ ❑ School _____ ❑ Other _____

List any broken bones (fractures) or dislocations : _____

Ever on crutches? ❑ No ❑ Yes 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? ❑ No ❑ Yes 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? ❑ No ❑ Yes What drugs? _____

I hereby authorize the Doctor to examine and treat my condition as he 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 _____