NAME:

Please mark whether you have these symptoms by writing a "C" for currently or a "P" for in the past, and when applicable please write RIGHT or LEFT side. We want all the facts about your health before we accept your case. THIS IS A CONFIDENTIAL HEALTH REPORT

NEUROLOGICAL

_____ SEIZURES / CONVULSIONS
_____ DIZZINESS / FAINTING
_____ HEADACHE(S)
_____ NUMBNESS / TINGLING
_____ CARPAL TUNNEL
_____CONCUSSION

MUSCLE & JOINT

_____ NECK
_____ UPPER / MID BACK
_____ SHOULDER(S)
_____ ARM(S)
_____ ELBOW(S)
_____ WRIST(S)
_____ HAND(S)
_____ LOW BACK
_____ HIP(S)
_____ LEG(S)
_____ KNEE(S)
_____ FOOT
_____ ARTHRITIS
_____ BURSITIS
_____ FIBROMYALGIA
_____ ARTIFICIAL JOINT

GASTRO-INTESTINAL

_____ COLON TROUBLE
_____ CONSTIPATION
_____ DIARRHEA
_____ DIFFICULT DIGESTION
_____ DISTENSION OF ABDOMEN
_____ GALL BLADDER TROUBLE
_____ HEMORRHOIDS
_____ LIVER TROUBLE
_____ STOMACH PAIN / CRAMPS

EYES, EARS, NOSE & THROAT

_____ LOSS OF HEARING
_____ EARACHE
_____ RINGING IN EAR(S)
_____ VISION ISSUES
_____ SINUS INFECTION

CARDIOVASCULAR

_____ HARDENING OF ARTERIES
_____ HIGH / LOW BLOOD PRESSURE (circle one)
_____ PAIN OVER HEART
_____ POOR CIRCULATION
_____ RAPID/ SLOW HEART BEAT
_____ PACEMAKER / DEFIBRILLATOR
_____ SWELLING OF ANKLES

RESPIRATORY

_____ CHEST PAIN
_____ CHRONIC COUGH
_____ DIFFICULTY BREATHING / ASTHMA
_____ SPITTING UP BLOOD / PHLEGM

GENITO-URINARY

_____ BED-WETTING
_____ BLOOD IN URINE
_____ KIDNEY INFECTION / STONES
_____ PAINFUL URINATION
_____ PROSTATE TROUBLE

FOR WOMEN ONLY

_____ NUMBER OF CHILDREN
_____ AGES OF CHILDREN
_____ BREAST PAIN / CONGESTED
_____ CRAMPS OR BACKACHE
_____ IRREGULAR / PAINFUL CYCLE
_____ MENOPAUSAL SYMPTOMS
PREGNANT? (CIRCLE) YES or NO
DATE OF LAST PERIOD _____
PAST MISCARRIAGE(S)? YES / NO (circle)

CHECK IF YOU HAVE THESE HABITS
CIRCLE IF YOU HAD THESE HABITS

____COFFEE
____DRUGS
____TOBACCO
____ALCOHOL

CHECK IF YOU HAVE EVER HAD or BEEN:

____CHIROPRACTIC TREATMENT
____ORTHOPEDIC / NEUROLOGIST CARE
____PAIN CLINIC
____PHYSCIAL THERAPY
____CORTISONE /TP / EPIDURAL INJECTIONS
____A FRACTURED BONE

DATE OF LAST: (APPROX.)

_____ PHYSICAL EXAMINATION
_____ SPINAL X-RAY / CT / MRI

***CHECK* THE FOLLOWING CONDITIONS *YOU HAVE OR HAVE HAD*.**
CIRCLE THE ITEMS THAT ARE COMMON TO *OTHER FAMILY MEMBERS*

____DIABETES	**____EMPHYSEMA**	**____DEMENTIA / ALZHEIMER'S**
____CANCER	**____APPENDICITUS**	**____PARKINSON'S**
____STROKE	**____ARTHRITIS**	**____MULT. SCLEROSIS**
____HEPATITIS	**____ULCERS**	**____ALCOHOLISM**
____HEART DZ	**____PSYCHOLOGICAL DISORDERS / DEPRESSION**	

PLEASE LIST ALL MEDICATIONS, VITAMINS & SUPPLEMENTS YOU ARE CURRENTLY TAKING:

_____
_____
_____

AFTER READING & FILLING OUT THE HEALTH QUESTIONNAIRE, YOUR SIGNATURE WILL VERIFY THAT ALL OF THE INFORMATION YOU HAVE GIVEN US IS ACCURATE & THAT YOU HAVE UNDERSTOOD & READ THE CASE HISTORY QUESTIONS CAREFULLY. THANK YOU.

PATIENT SIGNATURE: *X*_____ DATE: _____