

1 WHERE DOES IT HURT?

Please check the appropriate box for any of the following symptoms which you have or have had previously. It is essential for us to understand your complete medical history prior to presenting treatment.

Name			Date
(Last)	(First)	(Middle)	
Birth date	Height	Weight	Sex

Key: O = Occasional F = Frequent C = Constant

O	F	C		O	F	C	
			General				Skin
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Boils
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bruise easily
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dryness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hives or allergy
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Itching
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin eruptions (rash)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Varicose veins
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Headache				
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loss of sleep	O	F	C	Muscle & Joint
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loss of weight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nervousness/depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bursitis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neuralgia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Foot trouble
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Numbness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hernia
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sweats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Low back pain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tremors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neck pain or stiffness
			Respiratory				
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain between shoulders
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic cough				Pain or numbness in:
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficult breathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shoulders
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Spitting up blood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arms
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Spitting up phlegm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Elbows
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hands
			Cardio-Vascular				
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hardening of arteries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hips
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Legs
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Knees
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain over heart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Feet
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Poor circulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Painful tail bone
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rapid heart beat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Poor posture
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Slow heart beat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sciatica
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Swelling of ankles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Spinal curvature
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Swollen joints

CONFIDENTIAL HEALTH REPORT

Key: O = Occasional

F = Frequent

C = Constant

O	F	C	Ears, Eyes, Nose & Throat
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Colds
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Crossed eyes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Deafness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dental decay
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Earache
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ear discharge
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ear noises
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Enlarged glands
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Enlarged thyroid
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eye pain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Failing vision
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Far sightedness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gum trouble
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hay fever
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hoarseness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Near sightedness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nosebleeds
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus infection
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sore throat
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tonsillitis

O	F	C	Genito-Urinary
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bed-wetting
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood in urine
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent urination
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Inability to control kidneys
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney infection or stones
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Painful urination
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Prostate trouble
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pus in urine

O	F	C	Gastro -Intestinal
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Belching or gas
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Colitis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Colon trouble
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficult digestion
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Distension of abdomen
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excessive hunger
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gall bladder trouble
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Inability to control colon
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Liver trouble
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nausea
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain over stomach
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Poor appetite
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting blood

O	F	C	For Women Only
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Congested breasts
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cramps or backache
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excessive menstrual flow
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hot flashes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Irregular cycle (spotting)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Menopausal symptoms
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Painful menstruation
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vaginal discharge
			Are you pregnant? yes <input type="checkbox"/> no <input type="checkbox"/>
			Date of last period: _____
			Last Pap Smear: _____
			Did you ever have a positive Pap Smear? yes <input type="checkbox"/> no <input type="checkbox"/>

Doctor's comments:

3 CONFIDENTIAL HEALTH REPORT

Key:

N = None L = Light M = Moderate H = Heavy

Date of Last: (approx.)

_____ Physical examination
_____ Blood test
_____ Chest x-ray
_____ Spinal x-ray
_____ Dental x-ray
_____ Urine test

N L M H Lifestyle

Alcohol
 Coffee
 Tobacco
 Drugs:
 Exercise:

Please list any prescription drugs now taken:

Have You Ever:

- | | |
|--|--|
| <input type="checkbox"/> Been knocked unconscious? | <input type="checkbox"/> Had a fractured bone? |
| <input type="checkbox"/> Use a crutch or other support? | <input type="checkbox"/> Been hospitalized for other than surgery? |
| <input type="checkbox"/> Been treated for a spine or nerve disorder? | <input type="checkbox"/> Ever had surgery? (list below) |

Please list any allergies and past surgeries:

Check the following conditions you have had Circle items that are common to other family members

- | | | | | |
|---|-------------------------------------|---|---|---|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Cold Sores | <input type="checkbox"/> Fever blisters | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Gout | <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Scarlet fever |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Mumps | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Eczema | <input type="checkbox"/> Influenza | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Lumbago | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Measles | <input type="checkbox"/> Polio | <input type="checkbox"/> Venereal disease |

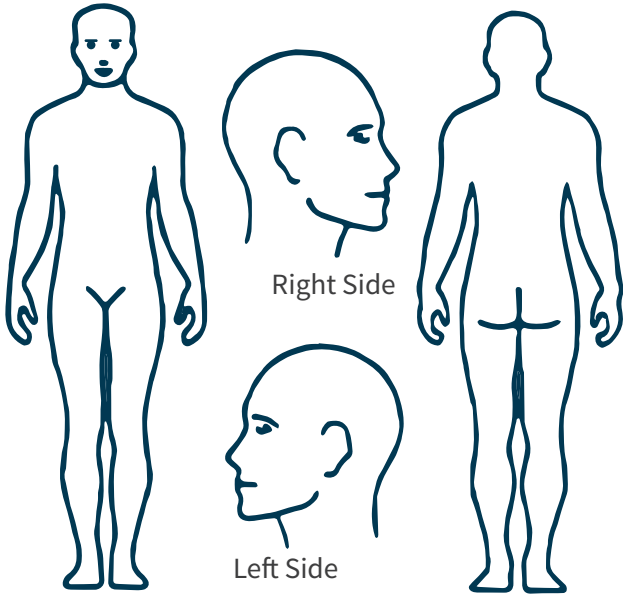
Have you ever had previous chiropractic care? yes no

If yes, date of last care:

Doctor's comments:

CONFIDENTIAL HEALTH REPORT

Please mark your areas of pain on the figures below



Case History

Date you first noticed symptoms:

Describe major complaints and symptoms:

After reading and filling out the case history, your signature will verify that all the information you have given us is accurate and that you have read the case history questions entirely.

Signature

Date

• FEES PAYABLE WHEN SERVICE RECEIVED UNLESS SPECIAL ARRANGEMENTS ARE MADE •

Doctor's comments:
