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 Smear 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 the insurance company and me. The Doctor's office will prepare reports and forms necessary to assist me in the filing of my claim with the insurance company but cannot guarantee reimbursement from the insurance company. Direct payments made from the insurance company to the Doctor's office will be credited to my account upon receipt and any balances due will be my responsibility. All services rendered to me are my personal responsibility and I agree to make payment for these services to the Doctor's office. I also understand that if I suspend or terminate my care and treatment, any fees for services rendered will be immediately due and payable. Should third party collection become necessary, I agree to pay all fees involved in collection of the account.

I authorize the Doctor to examine and treat my condition as deemed appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. The amount paid to the Doctor's office for X-rays is for the examination only; the X-ray negatives will remain the property of the Doctor's office and will remain on file at the Doctor's office as long as I am a patient. I am the responsible party for payment of any treatment received or incurred on this account. This Doctor provides only chiropractic care and is not responsible for any pre-existing medically diagnosed conditions or for making any medical diagnosis.

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