CHECK ANY OF THE FOLLOWING CONDITIONS YOU HAVE OR HAVE HAD:

_____ ALCOHOLISM
_____ ANKYLOSING SPONDYLITIS
_____ ANXIETY
_____ ARM PAIN / NUMBNESS
_____ ASTHMA / BREATHING PROBLEM
_____ BACK PAIN
_____ BORN W/ BONE/JOINT DISORDER
_____ CANCER
_____ COMPRESSION FRACTURE
_____ CONVULSIONS/EPILEPSY
_____ DEGENERATIVE ARTHRITIS
_____ DEPRESSION
_____ DIABETES
_____ DIFFICULTY WITH STRESS
_____ DIGESTIVE TROUBLE
_____ DIZZINESS
_____ EMPHYSEMA
_____ EPILEPSY
_____ GOUT
_____ HEADACHE
_____ HEARING PROBLEM
_____ HEART ATTACK HEART DISORDER
_____ HEART DISEASE
_____ HEPATITIS B OR HIV INFECT
_____ HIGH BLOOD PRESSURE
_____ HIP, LEG, FOOT PROBLEM
_____ HISTORY STROKE OR ANEURYSM
_____ JAW / MOUTH PROBLEM
_____ KIDNEY TROUBLE
_____ LUPUS
_____ MENSTRUAL PROBLEMS
_____ MIGRAINES
_____ MULTIPLE SCLEROSIS
_____ MUSCLE SPASMS
_____ NAUSEA
_____ NERVOUSNESS
_____ NUMBNESS/TINGLING HANDS, FEET
_____ RADIATING PAIN
_____ PAINFUL TAIL BONE
_____ RESTRICTION MOVEMENT
_____ RHEUMATOID ARTHRITIS
_____ SCIATICA
_____ SHOULDER, ARM, HAND PROBLEM
_____ SINUS PROBLEMS
_____ SLEEPING TROUBLE
_____ SPINAL DISORDER
_____ STROKE
_____ THYROID OR HORMONE DISORDER
_____ TUBERCULOSIS
_____ ULCERS
_____ VISION PROBLEMS

_____ IMMUNE SUPPRESSION TREATMENT OR DISORDER FROM CHEMOTHERAPY, ORGAN TRANSPLANT, DRUG, ETC.
_____ 3 OR MORE MONTHS OF INTRAVENOUS DRUGS (PAST OR PRESENT).

OTHER CONDITIONS:

_____

_____

FOR FEMALE PATIENTS: ARE YOU PREGNANT? _____ YES _____ NO

PATIENT CONDITION

HAVE YOU HAD PREVIOUS CHIROPRACTIC CARE? YES _____ NO _____

DATE OF LAST CHIROPRACTIC TREATMENT: _____

NAME AND LOCATION OF DOCTOR:

_____

UNDER TREATMENT FOR WHAT CONDITION: _____

REASON FOR VISIT:

_____

WHEN DID YOUR SYMPTOMS APPEAR? _____

IS THIS CONDITION GETTING PROGRESSIVELY WORSE? _____ YES _____ NO _____ UNKNOWN

Rate the severity of your pain on a scale for 1 (least pain) to 10 (severe pain)

_____ SHARP
_____ BURNING
_____ ACHING
_____ DULL
_____ TINGLING
_____ SWELLING
_____ THROBBING
_____ CRAMPS
_____ SHOOTING
_____ NUMBNESS
_____ STIFFNESS
_____ OTHER _____

How often do you have this pain? _____

Is it constant or does it come and go? _____

SPECIFIC PAIN IN THE BODY

_____ NECK PAIN WITH DIFFICULTY SWALLOWING
_____ EXTREME NECK STIFFNESS WITH PAIN OR ELECTRIC SHOCKS IN ARMS OR LEGS WHEN MOVING NECK.
_____ LEG PAIN THAT WORSENS WITH EXERCISE.
_____ NUMBNESS OF INNER THIGHS.
_____ BACK PAIN WITH URINARY PROBLEMS.
_____ SEVERE PAIN THAT INTERRUPTS SLEEP.
_____ CONSTANT PAIN THAT DOESN'T IMPROVE BY CHANGING POSITIONS OR BY LYING DOWN.