

Health

Please list any medications (including pain killers) you are taking: _____

Please list any serious injuries you have had in the past 10 years:

Description	Date
Falls	_____
Head Injuries	_____
Broken Bones	_____
Dislocations	_____
Surgeries	_____
Other	_____

Women: Are you pregnant? Y N If so, how far along? _____ Nursing? Y N

Medical History Past & Present

Check (✓) yes or no whether you have had or currently have any of the following medical conditions?

- | | | |
|---|--|---|
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart Attach/Stroke | <input type="checkbox"/> Y <input type="checkbox"/> N Psychiatric Problems | <input type="checkbox"/> Y <input type="checkbox"/> N Diabetes |
| <input type="checkbox"/> Y <input type="checkbox"/> N Congenital Heart Defect | <input type="checkbox"/> Y <input type="checkbox"/> N Difficulty Breathing | <input type="checkbox"/> Y <input type="checkbox"/> N Liver Problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart Disease | <input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis | <input type="checkbox"/> Y <input type="checkbox"/> N Bleeding Tendency |
| <input type="checkbox"/> Y <input type="checkbox"/> N High Blood Pressure | <input type="checkbox"/> Y <input type="checkbox"/> N Anemia | <input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis (TB) |
| <input type="checkbox"/> Y <input type="checkbox"/> N Epilepsy/Seizures | <input type="checkbox"/> Y <input type="checkbox"/> N Arthritis | <input type="checkbox"/> Y <input type="checkbox"/> N Cancer |
| <input type="checkbox"/> Y <input type="checkbox"/> N Shingles | <input type="checkbox"/> Y <input type="checkbox"/> N Kidney Disease | <input type="checkbox"/> Y <input type="checkbox"/> N Glaucoma |
| <input type="checkbox"/> Y <input type="checkbox"/> N Gout | <input type="checkbox"/> Y <input type="checkbox"/> N Neck Problem | <input type="checkbox"/> Y <input type="checkbox"/> N Leg Pain/Ankle Pain |
| <input type="checkbox"/> Y <input type="checkbox"/> N Ulcers | <input type="checkbox"/> Y <input type="checkbox"/> N Broken Bones | <input type="checkbox"/> Y <input type="checkbox"/> N Hip Pain |
| <input type="checkbox"/> Y <input type="checkbox"/> N Nervous Condition | <input type="checkbox"/> Y <input type="checkbox"/> N Jaw Pain | <input type="checkbox"/> Y <input type="checkbox"/> N Knee Pain |
| <input type="checkbox"/> Y <input type="checkbox"/> N Allergies | <input type="checkbox"/> Y <input type="checkbox"/> N Wrist Pain | <input type="checkbox"/> Y <input type="checkbox"/> N Abdominal Pain |
| <input type="checkbox"/> Y <input type="checkbox"/> N Previous Foot Condition | <input type="checkbox"/> Y <input type="checkbox"/> N Shoulder Pain | <input type="checkbox"/> Y <input type="checkbox"/> N Alcohol/Drug Abuse |
| <input type="checkbox"/> Y <input type="checkbox"/> N Back Problem | <input type="checkbox"/> Y <input type="checkbox"/> N Arm Pain/Hand Pain | |

Check if any of the following symptoms are present at this time.

Eyes:

- Y N Glasses
- Y N Pain
- Y N Spots
- Y N Double Vision

Ears:

- Y N Pain
- Y N Ringing/Noises
- Y N Hearing Loss
- Y N Loss of Balance

Head:

- Y N Headaches
- Y N Trauma
- Y N Dizziness
- Y N Fainting

Muscle & Joints:

- Y N Muscle Pain
- Y N Muscle Cramps
- Y N Muscle Weakness
- Y N Joint Pain
- Y N Joint Stiffness
- Y N Grinding/Popping
- Y N Loss of Flexibility

Nervous System:

- Y N Numbness
- Y N Tingling (pins & needles)
- Y N Nervousness
- Y N Coordination problems
- Y N Convulsions

Abdominal:

- Y N Pain
- Y N Gas
- Y N Burning
- Y N Nausea/Vomiting
- Y N Diarrhea/Constipation

Heart & Lungs

- Y N Chest Pain
- Y N Coughing
- Y N Sputum production
- Y N Chest Noises
- Y N Difficulty Breathing

Menstrual/Obstetrical

- Y N Cramps
- Y N Difficult Deliveries
- Y N Breast Tenderness
- Y N Breast Lumps

Personal – Check best answer

- Alcohol Heavy Light None
- Coffee Heavy Light None
- Tobacco Heavy Light None
- Drugs Heavy Light None
- Exercise How often? _____
- Sleep How many Hrs.? _____
- Appetite Good Bad Other

Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the Chiropractor to help determine appropriate and healthful chiropractic treatment. If there is any change in my medical status, I will inform the Chiropractor.

I authorize my insurance company to pay the chiropractor or chiropractic group all insurance benefits otherwise payable to me for services rendered.

I authorize the use of this signature on all insurance submissions. I authorize the chiropractor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature of patient or Guarantor: _____ Date: _____