Please enter: "2" (Previously), "3" (Presently), in front of all of the following signs and symptoms. Leave blank if not applicable. A complete history and understanding of your health will facilitate care.

GENERAL SYMPTOMS

_____	784.0	Headache
_____	780.6	Fever
_____	780.9	Chills
_____	780.8	Night Sweats
_____	780.2	Fainting
_____	780.4	Dizziness
_____	780.3	Convulsions
_____	780.52	Loss of Sleep
_____	780.7	Fatigue
_____	799.2	Nervousness
_____	783	Loss of Weight
_____	782	Numbness or pain in arms/legs/hands
_____	995.3	Allergy (What)
_____	786.09	Wheezing
_____	729.2	Neuralgia

GASTRO-INTESTINAL

_____	783	Poor Appetite
_____	536.8	Poor Digestion
_____	994.2	Excessive Hunger
_____	787.3	Belching or Gas
_____	787	Nausea
_____	787	Vomiting
_____	578	Vomiting Blood
_____	536.8	Pain over Stomach
_____	564	Constipation
_____	558.9	Diarrhea
_____	789	Colon Trouble
_____	455.6	Hemorrhoids (Piles)
_____	785.1	Liver Trouble
_____	782.4	Jaundice
_____	575.9	Gall Bladder Trouble

EYE/EAR/NOSE/THROAT

_____	368.9	Poor Vision
_____	378.9	Crossed Eyes
_____	379.91	Pain in Eyes
_____	389.9	Deafness
_____	388.70	Earache
_____	388.30	Ear Noises
_____	388.60	Ear Discharges
_____	478.1	Nasal Obstruction
_____	784.7	Nose Bleeds
_____	462	Sore Throats
_____	784.49	Hoarseness
_____	477.9	Hay Fever
_____	493.9	Asthma
_____	460	Frequent Colds
_____	240.9	Enlarged Thyroid
_____	463	Tonsillitis
_____	686.9	Sinus Trouble

RESPIRATORY

_____	786.2	Chronic Cough
_____	786.3	Spitting Blood
_____	933.1	Spitting Phlegm
_____	786.50	Chest Pain
_____	786.09	Difficulty Breathing

GENITO-URINARY

_____	788.3	Frequent Urination
_____	788.1	Painful Urination
_____	599.7	Blood in Urine
_____	592	Kidney Infection
_____	788.3	Bed Wetting
_____	788.1	Inability to control Urine
_____	601.9	Prostate Trouble

MUSCLES & JOINTS

_____		Weakness
_____		Twitching
_____	847	Stiff Neck
_____	722.10	Backache
_____	719	Swollen Joints
_____	781	Tremors
_____	729.5	Foot Trouble
_____	724.79	Painful Tail Bone
_____	724.5	Pain Between Shoulders
_____	563.3	Hernia
_____	737.3	Spinal Curvature

CARDIO-VASCULAR

_____	783	Rapid Heart
_____	427.89	Slow Heart
_____	401.9	High Blood Pressure
_____	458.9	Low Blood Pressure
_____	786.51	Pain over Heart
_____	438	Previous Heart Trouble
_____	719.07	Swelling Ankles
_____	759.9	Poor Circulation
_____		Varicose Veins
_____	436	Strokes

SKIN OR ALLERGIES

_____	368.9	Skin Eruptions
_____	698.9	Itching
_____	278.8	Bruising Easily
_____	701.1	Dryness
_____		Boils
_____	782	Sensitive Skin
_____	708.9	Hives or Allergy
_____	692.9	Eczema
_____		Medicines
		_____
		_____

FOR WOMEN ONLY

_____	786.2	Painful Periods
_____	626.2	Excessive Flow
_____	626.4	Irregular Cycle
_____	627.2	Hot Flashes
_____	625.3	Cramps or Backaches
_____	634.9	Miscarriage
_____	623.5	Vaginal Discharge
_____		Pregnant at this Time
_____		Last Pap

By Whom _____

Other _____

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
	_____		_____		_____
	_____		_____		_____

List any accidents or falls and dates: ❒ Car _____ ❒ Recreational Vehicle _____ ❒ Sports _____

❒ School _____ ❒ Other _____

List any broken bones (fractures) or dislocations: _____

Ever on crutches? ❒ No ❒ Yes 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? ❒ No ❒ Yes 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? ☐ No ☐ Yes What drugs? _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in makin collection from the insurance company, and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly t me, and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to examine and treat my conditions as he deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed the amount paid the Doctc for X-rays is for examination only and the X-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at thi office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

Patient's Signature X _____ **Date** _____

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_____	Back Operation	_____	Rectal Surgery	_____	Stomach
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