

10) Describe any regular exercise routine (duration and frequency): _____

11) Please list any illness you have, and corresponding treatment if any: _____

12) Do you take any prescribed medication? Yes _____ No _____ Name: _____

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

Pneumonia	Mumps	Influenza	Intake:
Rheumatic Fever	Smallpox	Pleurisy	Coffee
Polio	Chicken Pox	Arthritis	Tea
Tuberculosis	Diabetes	Epilepsy	Alcohol
Whooping Cough	Cancer	Mental Disorders	Cigarettes
Anemia	Heart Disease	Lumbago	White Sugar
Measles	Thyroid	Eczema	

CHECK ANY OF THE FOLLOWING SYMPTOMS YOU HAVE HAD IN THE PAST SIX MONTHS:

MUSCULO-SKELETAL-----

Low Back Pain	Arm Pain	Walking Problems
Pain Between Shoulders	Joint Pain/Stiffness	Difficulty Chewing/Clicking Jaw
Neck Pain	General Stiffness	

NERVOUS SYSTEM-----

Nervous	Dizziness	Fainting
Numbness	Forgetfulness	Convulsions
Paralysis	Confusion/Depression	Cold/Tingling Extremities
Stress		

GENERAL-----

Fatigue	Fever
Allergies	Headaches
Loss of Sleep	

GASTROINTESTINAL-----

Poor/Excessive Appetite	Constipation	Weight Trouble
Excessive Thirst	Hemorrhoids	Gall Bladder Problems
Frequent Nausea	Liver Problems	Abdominal Cramps
Vomiting	Diarrhea	Gas/Bloating After Meals
Heartburn	Black/Bloody Stools	Colitis

GENITO-RINARY-----

Bladder Trouble
Painful/Excessive Urination
Discolored Urine

C-V-R- CODE-----

Chest Pain	Lung Problems/Congestion
Short Breath	Varicose Veins
Blood Pressure Problems	Ankle Swelling
Irregular Heartbeat	Stroke
Heart Problems	

EENT CODE-----

Vision Problems	Earaches
Dental Problems	Hearing Difficult
Sore Throat	Stuffed Nose

FEMALES ONLY-----

When was your last period?

Are you pregnant?
Yes No

MALES/FEMALE CODE-----

Menstrual Irregularity	Breast Pain/Lumps
Menstrual Cramps	Prostate Sexual Dysfunction
Vaginal Pain/Lumps	

OTHER PROBLEMS-----

FAMILY HISTORY-----

The following members have the same
Or similar problem(s) as I do:

- Mother
- Father
- Brother
- Sister
- Spouse
- Child

Insurance Information:

Are you covered by health insurance? Yes _____ No _____

Name of insured _____ Relationship of insured _____

Name of Insurance Company: _____

Policy # _____ Group # _____

Amount of patient co-payment per office visit _____

--or--

Percentage covered by health insurance _____

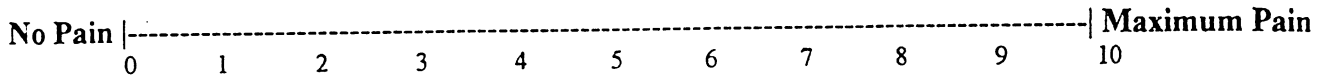
Have you met your deductible this year? Yes _____ No _____ Deductible amount _____

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic office will prepare any necessary reports and form to assist me in making collection from the insurance companies. However, I clearly understand and agree that all services rendered to me are charged to me and that ultimately, I am personally responsible for payment.

Patient signature _____ Date _____

Patient Name: _____ Date _____

1) Indicate with a **mark** on this line, the level of pain you are now experiencing:



2) Listed below are **5 types** of pain. **Select the type** (or types) of pain that you are experiencing.

3) Mark the body figures (**draw below**) to indicate where on your body the pain is being felt.

Be sure to **use the corresponding symbols** for each type of pain.

4) Please **draw your face** on the figure below.

XXXXXX
 Numbness XXXXXXXXXXXX
 XXXXXX

SSSSS
 Stabbing SSSSSSSSS
 SSSSS

/////////
 Ache ///////////////
 ///////////

Pins and Needles
 OOOOO
 OOOOOOOOOO
 OOOOO

Burning
 +++++
 ++++++++
 +++++

