

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
780.99 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)
786.07 Wheezing
729.2 Neuralgia

GASTRO-INTESTINAL

- 783. Poor Appetite
536.8 Poor Digestion
994.2 Starvation
787.3 Belching or Gas
787.0 Nausea
787.0 Vomiting
578.0 Vomiting Blood
536.8 Pain over Stomach
564.0 Constipation
787.91 Diarrhea
562.1 Colon Trouble
455.6 Hemorrhoids (Piles)
776.7 Fluid Retention
873.9 Liver Trouble
274. Gout
782.4 Jaundice
575.9 Gall Bladder Trouble

EYE/EAR/NOSE/THROAT

- 368.9 Poor Vision
378.0 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
473. Sinus Trouble

RESPIRATORY

- 786.2 Chronic Cough
786.3 Spitting Blood
786.4 Spitting Phlegm
786.50 Chest Pain
786.09 Difficulty Breathing

GENITO-URINARY

- 788.4 Frequent Urination
788.1 Painful Urination
599.7 Blood in Urine
590. Kidney Infection
788.3 Bed Wetting
788.3 Inability to control Urine
601.9 Prostate Trouble

MUSCLES & JOINTS

- 728.9 Weakness
781.0 Twitching
723.5 Stiff Neck
724.5 Backache
719.0 Swollen Joints
781. Tremors
729.5 Foot Trouble
724.79 Painful Tail Bone
724.5 Pain Between Shoulders
737.3 Spinal Curvature

CARDIO-VASCULAR

- 785.0 Rapid Heart
427.89 Slow Heart
401.9 High Blood Pressure
458.9 Low Blood Pressure
786.51 Pain Over Heart
429.9 Heart Trouble
719.07 Swelling Ankles
459.9 Poor Circulation
454.9 Varicose Veins
436. Strokes
785.1 Palpitations

SKIN OR ALLERGIES

- 680. Skin Eruptions - No
698.9 Itching
924.9 Bruising Easily
701.1 Dryness
680.9 Boils
782. Sensitive Skin
708.9 Hives or Allergy
692.9 Eczema
Medicines

FOR WOMEN ONLY

- 625.3 Painful Periods
626.2 Excessive Flow
626.4 Irregular Cycle
627.2 Hot Flashes
625.3 Cramps or Backaches
623.5 Vaginal Discharge
Pregnant at this Time
Last Pap
By Whom
Other

IN PATIENT / OUT PATIENT OPERATIONS AND PROCEDURES - HOSPITALIZATION

Table with 4 columns: DATE, DATE, DATE, DATE. Rows include Vaccinations, Tonsillectomy, Gall Bladder, Back Operation, Other, Tubes in Ears, Appendectomy, Female Organs, Rectal Surgery, Other, Sinus, Hernia, Thyroid, Stomach, Other.

Hospital Stays
Other Surgeries

List any accidents or falls/list dates: Car, Recreational Vehicle, Sports, School, Other

List any broken bones (fractures) or dislocations:

Have you ever been on crutches? Yes No Why?

Have you ever had a lapse of memory? Yes No Have you ever been unconscious? 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 List:

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 making collection from the insurance company...

I hereby authorize the Doctor to examine and treat my condition as he/she 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 Doctor for x-rays is for examination only and the x-ray negatives will remain the property of this office...

Patient Signature Date

Guardian Signature Date

Doctor Signature Date