PLEASE CHECK ANY OF THE FOLLOWING THAT GIVE YOU DIFFICULTY OR YOU HAVE HAD RECENTLY.

☐ HEADACHES 784.0	☐ FAINTING 780.2	☐ SHORTNESS OF BREATH 786.09	☐ ULCERS 534.9
☐ SHOOTING HEAD PAINS 784.0	☐ LOSS OF BALANCE 781.2	☐ MID-BACK PAIN 724.1	☐ NUMBNESS OF LEGS/FEET 782.0
☐ SINUS TROUBLE 473.9	☐ RINGING IN EARS 388.3	☐ HEART ATTACK 410.9	☐ CONSTIPATION 564.0
☐ LOSS OF SMELL 781.1	☐ BLURRED VISION 368.0	☐ HIGH BLOOD PRESSURE 401.9	☐ KIDNEY TROUBLE 593.9
☐ ALLERGIES 995.3	☐ LIGHTS HURT EYES 368.13	☐ LOW BLOOD PRESSURE 458.9	☐ MENSTRUAL CRAMP/PAIN 625.3
☐ HAYFEVER 477.8	☐ NECK PAIN 723.1	☐ ANEMIA 285.9	☐ MENSTRUAL IRREG. 626.4
☐ ASTHMA 493.9	☐ MUSCLE SPASM NECK 781.0	☐ STOMACH TROUBLE 789.0	☐ DIABETES 250.0
☐ LOSS OF TASTE 781.1	☐ GRINDING IN NECK 719.68	☐ NERVES/NERVOUSNESS 799.2	☐ SLEEPING PROBLEMS 780.5
☐ INFLAM. OF THROAT 462.0	☐ TIGHT SHOULDER & ARM 728.85	☐ INNER TENSION 799.2	☐ PAINFUL JOINTS 719.4
☐ THYROID TROUBLE 246.9	☐ PAIN IN SHOULDER/ARM 719.4	☐ IRRITABILITY 799.2	☐ SWOLLEN JOINTS 719.0
☐ FACE TWITCH 351.9	☐ PINS/NEEDLES IN ARMS/HANDS 782.0	☐ GALL BLADDER TROUBLE 575.9	☐ PINS/NEEDLES IN LEG 782.0
☐ FATIGUE 780.7	☐ COLD HANDS 782.0	☐ INDIGESTION 536.8	☐ SWOLLEN ANKLES 782.3
☐ DEPRESSION 311.0	☐ NUMBNESS IN ARM/HAND 782.0	☐ INTESTINAL GAS 787.3	☐ COLD FEET 782.0
☐ DIZZINESS 780.4	☐ COLD HAND/FINGERS 782.0	☐ LOW BACK PAIN 724.2	☐ PAIN IN LEG/FEET 719.46
☐ SPINAL CURVATURE 737.43	☐ TONSILITIS 784.0	☐ HERNIA 550.01	☐ HIP PAIN 719.45
☐ CHEST PAIN 786.5	☐ PROSTATE TROUBLE 601.4	☐ STROKE 436.0	
		☐ BED WETTING 788.3	

FAMILY HISTORY SECTION

DO ANY OF YOUR CHILDREN HAVE ANY OF THE FOLLOWING?

		NAME & AGE
HEADACHES	YES/NO	______
ALLERGIES	YES/NO	______
EAR INFECTIONS	YES/NO	______
FREQUENT COLDS	YES/NO	______
ASTHMA	YES/NO	______
CONSTANT IRRITABILITY	YES/NO	______
CONSTIPATION	YES/NO	______
GROWING PAINS	YES/NO	______
HYPER KINETIC	YES/NO	______
BLOODY NOSES	YES/NO	______
SCOLIOSIS	YES/NO	______
BEDWETTING	YES/NO	______

DO YOU OR ANY OF YOUR BLOOD RELATIVES HAVE ANY OF THE FOLLOWING? IF YESS WHAT RELATION TO YOU-

DIABETES	YES/NO	______
CANCER	YES/NO	______
STROKE	YES/NO	______
HEART PROBLEMS	YES/NO	______
SCOLIOSIS	YES/NO	______
BACK PROBLEMS	YES/NO	______
HEADACHES	YES/NO	______
ULCERS	YES/NO	______

HAVE ALL YOUR CHILDREN HAD A SCOLIOSIS EXAM BY A CHIROPRACTOR? **YES/NO**

HAVE ANY OF YOUR RELATIVES BEEN EXAMINED BY A CHIROPRACTOR? **YES/NO**

DO ANY OF THE PEOPLE YOU WORK WITH HAVE THE SAME HEALTH PROBLEMS AS YOU? **YES/NO** IF YES, PLEASE EXPLAIN- ______________________________

TO THE BEST OF YOUR KNOWLEDGE, ARE YOU PREGNANT, EITHER SUSPECTED OR CONFIRMED AT THIS PARTICLUAR TIME? **YES/NO**

** SERVICES ARE DUE AT TIME OF SERVICE. IF WE HAVE TO BILL YOU, A $5.00 FEE WILL APPLY.

** CONTACTING INSURANCE COMPANIES IS A COURTESY THAT WE DO FOR ALL PATIENTS, SOMETIMES WE ARE GIVEN THE WRONG OR INCOMPLETE INFORMATION. IF THIS HAPPENS, ANY OVER PAYMENTS WILL BE GIVEN IN THE FORM OF A CREDIT TOWARDS YOUR CARE. WE ADVISE THAT YOU ALSO CONTACT YOUR INSURANCE COMPANY TO VERIFY YOUR BENEFITS.

SIGNATURE ______________________________ DATE ______________