

Never	Previous	Present	GENERAL SYMPTOMS	Never	Previous	Present	RO-INTESTINAL	Never	Previous	Present	EYE/EAR/NOSE/T	Never	Previous	Present	RESPIRATORY
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	905.3 Allergy(What) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	77.3 Belching or Gas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	493.9 Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	786.50 Chest Pain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	491 Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	789.0 Colon Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	378.9 Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	786.2 Chronic Cough
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	780.9 Chills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	564.0 Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	389.9 Deafness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	786.09 Difficulty Breathing
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	780.3 Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	558.9 Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	388.70 Earache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	786.3 Spitting Blood
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	780.4 Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	783.6 Excessive Hunger	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	388.60 Ear Discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	786.4 Spitting Phlegm
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	780.2 Fainting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	575.9 Gall Bladder Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	388.30 Ear Noises				
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	780.7 Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	455.6 Hemorrhoids (piles)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	240.9 Enlarged Thyroid				GENITO-URINARY
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	780.6 Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	782.4 Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	460 Frequent Colds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	788.3 Bed Wetting
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	784.0 Headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	794.8 Liver Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	477.9 Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	599.7 Blood in Urine
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	780.52 Loss of Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	787.0 Nausea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	784.49 Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	788.4 Frequent Urination
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	783 Loss of weight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	536.8 Pain over Stomach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	478.1 Nasal Obstruction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	788.3 Inability to Control Urine
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	799.2 Nervousness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	783.0 Poor Appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	784.7 Nose Bleeds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	590.9 Kidney Infection
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	729.2 Neuralgia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	536.8 Poor Digestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	379.91 Pain in Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	788.1 Painful Urination
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	780.8 Night Sweats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	787.0 Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	368.9 Poor Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	788.1 Painful Urination
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	782 Numbness or pain in arms/legs/hands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	578.0 Vomiting Blood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	473.9 Sinusitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	601.9 Prostate Trouble
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	786.09 Wheezing					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	462 Sore Throats				
								<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	463 Tonsillitis				
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	MUSCLES & JOINTS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CARDIO-VASCULAR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	SKIN OR ALLERGIES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	FOR WOMEN ONLY
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	724.5 Backache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	401.9 High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	690 Boils	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	625.3 Cramps or Backaches
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	719.7 Foot Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	458.9 Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	924.9 Bruising Easily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	626.2 Excessive Flow
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	550.0 Hernia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	786.51 Pain over Heart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	701.1 Dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	627.2 Hot Flashes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	719.1 Pain Between Shoulders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	785.9 Poor Circulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	691.8 Eczema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	626.4 Irregular Cycle
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	724.6 Painful Tail Bone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	438 Previous Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	708.9 Hives or Allergy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	634.9 Miscarriage
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	723.9 Stiff Neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	785.0 Rapid Heart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	698.9 Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	625.3 Painful Periods
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	781.9 Spinal Curvature	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	427.89 Slow Heart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	782.0 Sensitive Skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	623.5 Vaginal Discharge
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	719.0 Swollen Joints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	436 Strokes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	368.9 Skin Eruptions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pregnant at this time
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	781.0 Tremors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	782.3 Swelling Ankles					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Last Pap Date
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	781.0 Twitching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	454 Varicose Veins					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	By Whom

OPERATIONS AND PROCEDURES

DATE _____	Vaccinations	DATE _____	Tubes in Ears	DATE _____	Sinus
_____	Tonsillectomy	_____	Appendectomy	_____	Hernia
_____	Gall Bladder	_____	Female Organs	_____	Thyroid
_____	Back Operation	_____	Rectal Surgery	_____	Stomach
_____	Other: _____	_____	Other: _____	_____	Other: _____

I have never had any operations / surgeries

List any accidents or falls and dates: Car: _____ Recreation Vehicle: _____
 Sports: _____ School: _____ Other: _____

List any broken bones(fractures) or dislocations: _____
 Ever on crutches? Yes No 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? 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? No Yes What drugs? _____

What other factors of your health have you not revealed perhaps because you are embarrassed by them, if any? _____

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 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 to 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 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, 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 this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

Patient's/Guardian's Signature: X _____ Date: _____