

HEALING HANDS CHIROPRACTIC

Patient Name (please print) _____ Date of Birth _____

Past Present

- Headache
- Neck Pain
- Upper Back Pain
- Mid Back Pain
- Low Back Pain
- Shoulder Pain
- Elbow / Upper Arm Pain
- Wrist Pain
- Hand Pain
- Hip / Upper Leg Pain
- Knee / Lower Leg Pain
- Ankle / Foot Pain
- Jaw Pain
- Scoliosis
- Joint Swelling / Stiffness
- Arthritis
- Rheumatoid Arthritis

- General Fatigue
- Muscular Incoordination
- Fainting
- Visual Disturbances
- Convulsions
- Dizziness
- Tinnitus (ear noises)

- Cancer
- Tumor

Past Present

- High Blood Pressure
- Heart Attack
- Chest Pains
- Stroke
- Rapid Heart Beat
- Angina
- Aortic Aneurysm
- Blood Disorder

- Kidney Stones
- Kidney Disorders
- Bladder Infection
- Painful Urination
- Loss of Bladder Control
- Prostate Problems

- Abnormal Weight Gain / Loss
- Anorexia
- Loss of Appetite
- Abdominal Pain
- Difficulty Swallowing
- Constipation
- Heartburn Indigestion
- Ulcer
- Colitis
- Irritable Colon
- Hepatitis
- Liver / Gall Bladder Disorder

Past Present

- Emphysema
 - Asthma
 - Chronic Cough
 - Chronic Sinusitis
 - Diabetes
 - Excessive Thirst
 - Frequent Urination
 - Systemic Lupus
 - Epilepsy
- Dermatitis / Eczema / Rash
- Depression
 - Drug / Alcohol Dependence
 - HIV/AIDS

Allergies: _____

Females Only:

First Day of last menstrual cycle: _____

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- Irregular Menstrual Flow
 - Profuse Menstrual Flow
 - Breast Soreness / Lumps
 - Endometriosis
 - PMS
 - Birth Control Pills
 - Hormonal Imbalance
 - Pregnancy

TOBACCO USE: Non-Smoker Sometimes Smoker Everyday Smoker Smokeless Tobacco Per Day Use _____
 FORMER SMOKER: (choose one) < 1 year 1-2 years 3-4 years 5+ years 10+ years

Indicate if any family member has ever had any of the following:

- Chronic Back problems
- Rheumatoid Arthritis
- High Blood Pressure
- Cancer
- Lupus
- Chronic Headaches
- Lung Problems
- Heart problems
- Diabetes
- Other

Do you have a permanent disability rating? Yes No Rating % _____ Date rating received _____

Describe your disability _____

List all prescription and over-the-counter medications you are taking _____

List all surgical procedures you have had and times you have been hospitalized _____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to do whatever is necessary in accordance with this state's statues, to provide me with chiropractic care.

Patient or Guardian Signature _____ **Date** _____