HEALING HANDS CHIROPRACTIC

Patient Name (please print)_____Date of Birth_____

Past	Present		Past	Present		Past	Present	
❒	❒	Headache	❒	❒	High Blood Pressure	❒	❒	Emphysema
❒	❒	Neck Pain	❒	❒	Heart Attack	❒	❒	Asthma
❒	❒	Upper Back Pain	❒	❒	Chest Pains	❒	❒	Chronic Cough
❒	❒	Mid Back Pain	❒	❒	Stroke	❒	❒	Chronic Sinusitis
❒	❒	Low Back Pain	❒	❒	Rapid Heart Beat	❒	❒	Diabetes
❒	❒	Shoulder Pain	❒	❒	Angina	❒	❒	Excessive Thirst
❒	❒	Elbow / Upper Arm Pain	❒	❒	Aortic Aneurysm	❒	❒	Frequent Urination
❒	❒	Wrist Pain	❒	❒	Blood Disorder	❒	❒	Systemic Lupus
❒	❒	Hand Pain				❒	❒	Epilepsy
❒	❒	Hip / Upper Leg Pain	❒	❒	Kidney Stones	Dermatitis / Eczema / Rash		
❒	❒	Knee / Lower Leg Pain	❒	❒	Kidney Disorders			
❒	❒	Ankle / Foot Pain	❒	❒	Bladder Infection	❒	❒	Depression
❒	❒	Jaw Pain	❒	❒	Painful Urination	❒	❒	Drug / Alcohol Dependence
❒	❒	Scoliosis	❒	❒	Loss of Bladder Control	❒	❒	HIV/AIDS
❒	❒	Joint Swelling / Stiffness	❒	❒	Prostate Problems			
❒	❒	Arthritis				**Allergies:**_____		
❒	❒	Rheumatoid Arthritis	❒	❒	Abnormal Weight Gain / Loss			
			❒	❒	Anorexia	**Females Only:**		
❒	❒	General Fatigue	❒	❒	Loss of Appetite	First Day of last menstrual cycle:		
❒	❒	Muscular Incoordination	❒	❒	Abdominal Pain			
❒	❒	Fainting	❒	❒	Difficulty Swallowing	❒	❒	Irregular Menstrual Flow
❒	❒	Visual Disturbances	❒	❒	Constipation	❒	❒	Profuse Menstrual Flow
❒	❒	Convulsions	❒	❒	Heartburn Indigestion	❒	❒	Breast Soreness / Lumps
❒	❒	Dizziness	❒	❒	Ulcer	❒	❒	Endometriosis
❒	❒	Tinnitus (ear noises)	❒	❒	Colitis	❒	❒	PMS
			❒	❒	Irritable Colon	❒	❒	Birth Control Pills
❒	❒	Cancer	❒	❒	Hepatitis	❒	❒	Hormonal Imbalance
❒	❒	Tumor	❒	❒	Liver / Gall Bladder Disorder	❒	❒	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**_____