HIGLEY
FAMILY CHIROPRACTIC
Discover the Difference

Patient Name_____

Describe Major Complaints and Symptoms_____
_____
_____

Date You First Noticed Symptoms_____ How Was The Condition Caused_____

Has This Condition Happened Before _____When_____ Name of Doctor_____

Diagnosis_____ Length of Time Under Care_____ Results_____

Have You Ever Been In An Accident_____ Auto, Work, Home, Leisure, Other_____

Describe Including Date(s) _____

Describe Fractures (Past or Present) _____

Describe Any Type Of Surgery _____

Describe The Medication You Are Taking For Any Condition_____

The Past Have You Taken Medication On A Regular Basis _____ Date Of Last Medical Exam_____

Date Of Last Chiropractic Exam_____

CHECK THE FOLLOWING CONDITIONS YOU HAVE HAD

___Anemia	___Diptheria	___Multiple Sclerosis	___ Tonsillitis
___Appendicitis	___Eczema	___Mumps	___Tuberculosis
___Arteriosclerosis	___Emphysema	___Pleurisy	___Typhoid Fever
___Asthma	___Epilepsy	___Pneumonia	___Whooping Cough
___Cancer	___Goiter	___Polio	___Other:
___Chicken Pox	___Heart Disease	___Rheumatic Fever	_____
___Cold Sores	___Hypoglycemia	___Scarlet Fever	_____
___Diabetes	___Measles	___Stroke	_____

SEE BACK SIDE→

Your signature below will verify that all the information you have given us is accurate and that you have answered the health report questions entirely.

Signature_____Date_____

PLEASE CHECK ANY OF THE FOLLOWING SYMPTOMS WHICH YOU NOW HAVE OR HAVE HAD IN THE PAST

NOW	PAST		NOW	PAST		NOW	PAST	
		GENERAL			**GASTRO-INTESTINAL**			**RESPIRATORY**
__	__	Allergy	__	__	Colon Trouble	__	__	Chest Pain
__	__	Chills	__	__	Constipation	__	__	Chronic Cough
__	__	Convulsions	__	__	Diarrhea	__	__	Difficult Breathing
__	__	Depression	__	__	Difficult Digestion	__	__	Wheezing
__	__	Dizziness	__	__	Gall Bladder Trouble			
__	__	Fainting	__	__	Hemorrhoids			**GENITO-URINARY**
__	__	Headache	__	__	Jaundice	__	__	Bed Wetting
__	__	Loss of Sleep	__	__	Liver Trouble	__	__	Blood in Urine
__	__	Loss of Weight	__	__	Pain over Stomach	__	__	Frequent Urination
__	__	Nervousness	__	__	Ulcers	__	__	Can't Control Urine
__	__	Tremors				__	__	Painful Urination
					E.E.N.T.	__	__	Prostate Trouble
		MUSCLE & JOINT	__	__	Crossed Eyes	__	__	Puss in Urine
__	__	Arthritis	__	__	Deafness			
__	__	Bursitis	__	__	Earache			**FOR WOMEN ONLY**
__	__	Hernia	__	__	Enlarged Glands	__	__	Cramps or Backache
__	__	Low back pain	__	__	Eye Flashes	__	__	Excessive Flow
__	__	Neck Pain or Stiffness	__	__	Eye Pain	__	__	Hot Flashes
__	__	Pain Between Shoulders	__	__	Hay fever	__	__	Irregular Cycle
			__	__	Hoarseness	__	__	Lumps in Breast
		Pain or Numbness in:	__	__	Nasal Obstruction	__	__	Menopausal Symptoms
__	__	Shoulders	__	__	Sinus Infection	__	__	Painful Menses
__	__	Arms	__	__	Sore Throat	__	__	Vaginal Discharge
__	__	Elbows				__	__	Miscarriage
__	__	Hands			**CARDIOVASCULAR**			
__	__	Hips	__	__	Hardening Arteries			Are You Pregnant
__	__	Legs	__	__	High Blood Pressure			YES _____ NO _____
__	__	Knees	__	__	Low Blood Pressure			
__	__	Feet	__	__	Pain Over Heart			
__	__	Painful Tailbone	__	__	Cold Hands or Feet			
__	__	Sciatica	__	__	Slow Beating Heart			
__	__	Swollen Joints	__	__	Rapid Heart Beat			
			__	__	Swelling Ankles			

Do not write below this area, for office use only.

Symptoms:

_____ _____

_____ _____

_____ _____

_____ _____

Other Notes: _____

_____

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