



EMBRACING LIFE CHIROPRACTIC

giving hope for a brighter tomorrow

Patient Name: _____

Date: _____

CARDIOVASCULAR

Present	Past	
<input type="checkbox"/>	<input type="checkbox"/>	Poor Circulation
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/>	Aortic Aneurysm
<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease
<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack
<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain
<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol
<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker
<input type="checkbox"/>	<input type="checkbox"/>	Jaw Pain
<input type="checkbox"/>	<input type="checkbox"/>	Irregular Heartbeat
<input type="checkbox"/>	<input type="checkbox"/>	Swelling of Legs
<input type="checkbox"/>	<input type="checkbox"/>	Stroke

ALLERGIC/IMMUNOLOGICAL

Present	Past	
<input type="checkbox"/>	<input type="checkbox"/>	Autoimmune Disorder
<input type="checkbox"/>	<input type="checkbox"/>	Chronic Allergies
<input type="checkbox"/>	<input type="checkbox"/>	Allergy Shots
<input type="checkbox"/>	<input type="checkbox"/>	Cortisone Use
<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS
<input type="checkbox"/>	<input type="checkbox"/>	Hives
<input type="checkbox"/>	<input type="checkbox"/>	Weak Immune System

GENITOURINARY

Present	Past	
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease
<input type="checkbox"/>	<input type="checkbox"/>	Lower Side Pain
<input type="checkbox"/>	<input type="checkbox"/>	Burning Urination
<input type="checkbox"/>	<input type="checkbox"/>	Frequent Urination
<input type="checkbox"/>	<input type="checkbox"/>	Blood in Urine
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stone
<input type="checkbox"/>	<input type="checkbox"/>	Bed Wetting/Enuresis
<input type="checkbox"/>	<input type="checkbox"/>	Rectal Prolapse
<input type="checkbox"/>	<input type="checkbox"/>	Prostate Problems

RESPIRATORY

Present	Past	
<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath
<input type="checkbox"/>	<input type="checkbox"/>	Upper Resp. Infection
<input type="checkbox"/>	<input type="checkbox"/>	Cold/Flu
<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia
<input type="checkbox"/>	<input type="checkbox"/>	Coughing/Wheezing
<input type="checkbox"/>	<input type="checkbox"/>	Emphysema
<input type="checkbox"/>	<input type="checkbox"/>	RSV
<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis

EYES

Present	Past	
<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma
<input type="checkbox"/>	<input type="checkbox"/>	Double Vision
<input type="checkbox"/>	<input type="checkbox"/>	Blurred Vision
<input type="checkbox"/>	<input type="checkbox"/>	Red, Itchy (Allergy)

EARS/NOSE/THROAT

Present	Past	
<input type="checkbox"/>	<input type="checkbox"/>	Sinus Congestion/Infection
<input type="checkbox"/>	<input type="checkbox"/>	Nosebleed
<input type="checkbox"/>	<input type="checkbox"/>	Sore Throat
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Swallowing
<input type="checkbox"/>	<input type="checkbox"/>	Ear Ache
<input type="checkbox"/>	<input type="checkbox"/>	Ear Infections
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Gums
<input type="checkbox"/>	<input type="checkbox"/>	Hearing Loss
<input type="checkbox"/>	<input type="checkbox"/>	Vertigo/Dizziness

GASTROINTESTINAL

Present	Past	
<input type="checkbox"/>	<input type="checkbox"/>	Pancreatitis
<input type="checkbox"/>	<input type="checkbox"/>	Acid Reflux
<input type="checkbox"/>	<input type="checkbox"/>	Bowel Problems
<input type="checkbox"/>	<input type="checkbox"/>	Constipation
<input type="checkbox"/>	<input type="checkbox"/>	Upset Stomach
<input type="checkbox"/>	<input type="checkbox"/>	Gas Pains
<input type="checkbox"/>	<input type="checkbox"/>	Ulcers
<input type="checkbox"/>	<input type="checkbox"/>	Gallbladder Problems
<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea
<input type="checkbox"/>	<input type="checkbox"/>	Nausea/Vomiting
<input type="checkbox"/>	<input type="checkbox"/>	Poor Appetite
<input type="checkbox"/>	<input type="checkbox"/>	Bloody Stools
<input type="checkbox"/>	<input type="checkbox"/>	Chrohn's Disease

PSYCHIATRIC

Present	Past	
<input type="checkbox"/>	<input type="checkbox"/>	Depression
<input type="checkbox"/>	<input type="checkbox"/>	Anxiety Disorder
<input type="checkbox"/>	<input type="checkbox"/>	Unusual Stress
<input type="checkbox"/>	<input type="checkbox"/>	OCD
<input type="checkbox"/>	<input type="checkbox"/>	Bipolar Disorder
<input type="checkbox"/>	<input type="checkbox"/>	Seasonal Affective Disorder
<input type="checkbox"/>	<input type="checkbox"/>	Mood Swings
<input type="checkbox"/>	<input type="checkbox"/>	Social Anxieties
<input type="checkbox"/>	<input type="checkbox"/>	Memory Loss

CONSTITUTIONAL

Present	Past	
<input type="checkbox"/>	<input type="checkbox"/>	Weight Loss/Gain
<input type="checkbox"/>	<input type="checkbox"/>	Energy Level Low
<input type="checkbox"/>	<input type="checkbox"/>	Energy Level High
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Sleeping
<input type="checkbox"/>	<input type="checkbox"/>	Chronic Fatigue
<input type="checkbox"/>	<input type="checkbox"/>	General Malaise
<input type="checkbox"/>	<input type="checkbox"/>	Compulsive Behavior
<input type="checkbox"/>	<input type="checkbox"/>	Learning Disabilities
<input type="checkbox"/>	<input type="checkbox"/>	Speech Delays
<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy/Fertility
<input type="checkbox"/>	<input type="checkbox"/>	RLS

NEUROLOGICAL

Present	Past	
<input type="checkbox"/>	<input type="checkbox"/>	Tic Disorder
<input type="checkbox"/>	<input type="checkbox"/>	Seizures
<input type="checkbox"/>	<input type="checkbox"/>	Head Injury
<input type="checkbox"/>	<input type="checkbox"/>	Brain Aneurysm
<input type="checkbox"/>	<input type="checkbox"/>	Numbness/Tingling
<input type="checkbox"/>	<input type="checkbox"/>	Pinched Nerves
<input type="checkbox"/>	<input type="checkbox"/>	Radiating Pain
<input type="checkbox"/>	<input type="checkbox"/>	Sciatica
<input type="checkbox"/>	<input type="checkbox"/>	Parkinson's Disease
<input type="checkbox"/>	<input type="checkbox"/>	Carpal Tunnel
<input type="checkbox"/>	<input type="checkbox"/>	Balance/Coordination
<input type="checkbox"/>	<input type="checkbox"/>	ADHD/ADD
<input type="checkbox"/>	<input type="checkbox"/>	Sensory Proc. Disorder
<input type="checkbox"/>	<input type="checkbox"/>	Autism/Spectrum Disorder
<input type="checkbox"/>	<input type="checkbox"/>	Migraine/Tension Headache
<input type="checkbox"/>	<input type="checkbox"/>	Bell's Palsy
<input type="checkbox"/>	<input type="checkbox"/>	Poor Fine/Gross Motor Skills
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy
<input type="checkbox"/>	<input type="checkbox"/>	Inflammation
<input type="checkbox"/>	<input type="checkbox"/>	Trigeminal Neuralgia
<input type="checkbox"/>	<input type="checkbox"/>	Ear Ringing/Tinnitus
<input type="checkbox"/>	<input type="checkbox"/>	Auditory Processing
<input type="checkbox"/>	<input type="checkbox"/>	Toe Walking
<input type="checkbox"/>	<input type="checkbox"/>	Sensory Integration
<input type="checkbox"/>	<input type="checkbox"/>	Sinus Headache

ENDOCRINE

Present	Past	
<input type="checkbox"/>	<input type="checkbox"/>	Hyper/Hypothyroid Issues
<input type="checkbox"/>	<input type="checkbox"/>	Type I/II Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Hair Loss
<input type="checkbox"/>	<input type="checkbox"/>	Menopausal
<input type="checkbox"/>	<input type="checkbox"/>	Menstrual Problems
<input type="checkbox"/>	<input type="checkbox"/>	Hot Flashes
<input type="checkbox"/>	<input type="checkbox"/>	Endometriosis
<input type="checkbox"/>	<input type="checkbox"/>	Polycystic Ovarian Syndrome
<input type="checkbox"/>	<input type="checkbox"/>	Graves Disease

MUSCULOSKELETAL

Present	Past	
<input type="checkbox"/>	<input type="checkbox"/>	Chronic Hip Dislocation
<input type="checkbox"/>	<input type="checkbox"/>	Torticollis
<input type="checkbox"/>	<input type="checkbox"/>	Joint Replacement
<input type="checkbox"/>	<input type="checkbox"/>	Neck Pain
<input type="checkbox"/>	<input type="checkbox"/>	Back Pain
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	Joint Stiffness
<input type="checkbox"/>	<input type="checkbox"/>	Muscle Weakness
<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis
<input type="checkbox"/>	<input type="checkbox"/>	Broken Bones
<input type="checkbox"/>	<input type="checkbox"/>	Gout