Loss of Whole Body Health (Age 5 - Present)

As you increased the layers of damage you probably began to experience symptoms and random bouts of sickness.

Yes	No	(Birth - Present)	Patient Comment (If answer is yes)	Chiropractor's Comments
❑	❑	Did /do you smoke?		
❑	❑	Did/do you drink any alcohol?		
❑	❑	Diet (Do you eat healthy foods?)		
❑	❑	Have you been in any accidents?		
❑	❑	Have you had surgery or organs removed/replaced?		
❑	❑	Drugs? (Prescription or non-prescription)		
❑	❑	Teeth problems?		
❑	❑	Eye problems?		
❑	❑	Hearing problems?		
❑	❑	Exercise regularly?		
❑	❑	Sleeping habits (nightmares/sleeplessness?)		
❑	❑	Did/do you have occupational stress?		
❑	❑	Physical stress?		
❑	❑	Mental stress?		
❑	❑	Hobby/Sports injuries?		
❑	❑	Other traumas or problems?		
❑	❑	Sleeping posture: ____ Side ____Stomach ____Back		

Present State of Health

(Please check most appropriate box)

❑ I have no special problems. I understand the role of chiropractic in my general health care & the importance of regular spinal check-ups.

❑ I have a DISEASE/SYMPTOM and I am interested in help with this specific problem. In addition I am interested in learning about my Health Potential and the role of chiropractic in improving my family's health.

❑ I have a DISEASE/SYMPTOM and I am interested in help with this problem and in learning how to prevent it in the future.

❑ I have a DISEASE/SYMPTOM and I am only interested in help with this specific problem.

Finally, the years of continuing damage showed up as acute or chronic symptoms.

Pain or Problem started on _____

Pains are: _____ Sharp _____ Dull _____ Constant _____ Intermittent

What activities aggravate your condition/pain? _____

What activities lessen your condition/pain? _____

Is condition worse during certain times of the day? _____

Is this condition interfering with your work? _____

Is this condition getting progressively worse? _____

Other Doctors seen for this condition: _____

Any home remedies? _____

Other symptoms:

___ Headaches	___ Neck Pain	___ Sleeping Problem	___ Back Pain	___ Nervousness	___ Tension
___ Irritability	___ Chest Pain	___ Dizziness	___ Face Flushed	___ Stiff Neck	___ Fatigue
___ Depression	___ Fever	___ Fainting	___ Loss of Smell	___ Loss of Taste	___ Diarrhea
___ Feet Cold	___ Hands Cold	___ Stomach Upset	___ Constipation	___ Cold Sweats	___ Loss of Balance
___ Ears Ring	___ Buzz in Ears	___ Pins & Needles in Legs	___ Pins & Needles in Arms		___ Lights Bother Eyes
___ Loss of Memory		___ Shortness of Breath	___ Numbness in Fingers		___ Numbness in Toes

For Women Only

Is there any possibility that you are pregnant? _____

Date of last menses: _____