

Please enter: "2" (Previously), "3" (Presently), in front of all of the following signs and symptoms. If not applicable, put NA. A complete history and understanding of your health will facilitate care. Behind condition, put number of times per month condition occurs.

**GENERAL SYMPTOMS**

- \_\_\_ 784.0 Headache
- \_\_\_ 780.6 Fever
- \_\_\_ 780.99 Chills
- \_\_\_ 780.8 Night Sweats
- \_\_\_ 780.2 Fainting
- \_\_\_ 780.4 Dizziness
- \_\_\_ 780.3 Convulsions
- \_\_\_ 780.52 Loss of Sleep
- \_\_\_ 780.7 Fatigue
- \_\_\_ 799.2 Nervousness
- \_\_\_ 783. Loss of Weight
- \_\_\_ 782. Numbness or pain in arms/legs/hands
- \_\_\_ 995.3 Allergy (What)
- \_\_\_ 786.07 Wheezing
- \_\_\_ 729.2 Neuralgia

**MUSCLES & JOINTS**

- \_\_\_ 728.9 Weakness
- \_\_\_ 781.0 Twitching
- \_\_\_ 723.5 Stiff Neck
- \_\_\_ 724.5 Backache
- \_\_\_ 719.0 Swollen Joints
- \_\_\_ 781. Tremors
- \_\_\_ 729.5 Foot Trouble
- \_\_\_ 724.79 Painful Tail Bone
- \_\_\_ 724.5 Pain Between Shoulders
- \_\_\_ 737.3 Spinal Curvature

**GASTRO-INTESTINAL**

- \_\_\_ 783. Poor Appetite
- \_\_\_ 536.8 Poor Digestion
- \_\_\_ 994.2 Starvation
- \_\_\_ 787.3 Belching or Gas
- \_\_\_ 787.0 Nausea
- \_\_\_ 787.0 Vomiting
- \_\_\_ 578.0 Vomiting Blood
- \_\_\_ 536.8 Pain over Stomach
- \_\_\_ 564.0 Constipation
- \_\_\_ 787.91 Diarrhea
- \_\_\_ 562.1 Colon Trouble
- \_\_\_ 455.6 Hemorrhoids (Piles)
- \_\_\_ 776.7 Fluid Retention
- \_\_\_ 873.9 Liver Trouble
- \_\_\_ 274. Gout
- \_\_\_ 782.4 Jaundice
- \_\_\_ 575.9 Gall Bladder Trouble

**CARDIO-VASCULAR**

- \_\_\_ 785.0 Rapid Heart
- \_\_\_ 427.89 Slow Heart
- \_\_\_ 401.9 High Blood Pressure
- \_\_\_ 458.9 Low Blood Pressure
- \_\_\_ 786.51 Pain Over Heart
- \_\_\_ 429.9 Heart Trouble
- \_\_\_ 719.07 Swelling Ankles
- \_\_\_ 459.9 Poor Circulation
- \_\_\_ 454.9 Varicose Veins
- \_\_\_ 436. Strokes
- \_\_\_ 785.1 Palpitations

**EYE/EAR/NOSE/THROAT**

- \_\_\_ 368.9 Poor Vision
- \_\_\_ 378.0 Crossed Eyes
- \_\_\_ 379.91 Pain in Eyes
- \_\_\_ 389.9 Deafness
- \_\_\_ 388.70 Earache
- \_\_\_ 388.30 Ear Noises
- \_\_\_ 388.60 Ear Discharges
- \_\_\_ 478.1 Nasal Obstruction
- \_\_\_ 784.7 Nose Bleeds
- \_\_\_ 462. Sore Throats
- \_\_\_ 784.49 Hoarseness
- \_\_\_ 477.9 Hay Fever
- \_\_\_ 493.9 Asthma
- \_\_\_ 460. Frequent Colds
- \_\_\_ 240.9 Enlarged Thyroid
- \_\_\_ 463. Tonsillitis
- \_\_\_ 473. Sinus Trouble

**SKIN OR ALLERGIES**

- \_\_\_ 680. Skin Eruptions - No
- \_\_\_ 698.9 Itching
- \_\_\_ 924.9 Bruising Easily
- \_\_\_ 701.1 Dryness
- \_\_\_ 680.9 Boils
- \_\_\_ 782. Sensitive Skin
- \_\_\_ 708.9 Hives or Allergy
- \_\_\_ 692.9 Eczema
- \_\_\_ Medicines

**RESPIRATORY**

- \_\_\_ 786.2 Chronic Cough
- \_\_\_ 786.3 Spitting Blood
- \_\_\_ 786.4 Spitting Phlegm
- \_\_\_ 786.50 Chest Pain
- \_\_\_ 786.09 Difficulty Breathing

**GENITO-URINARY**

- \_\_\_ 788.4 Frequent Urination
- \_\_\_ 788.1 Painful Urination
- \_\_\_ 599.7 Blood in Urine
- \_\_\_ 590. Kidney Infection
- \_\_\_ 788.3 Bed Wetting
- \_\_\_ 788.3 Inability to control Urine
- \_\_\_ 601.9 Prostate Trouble

**FOR WOMEN ONLY**

- \_\_\_ 625.3 Painful Periods
- \_\_\_ 626.2 Excessive Flow
- \_\_\_ 626.4 Irregular Cycle
- \_\_\_ 627.2 Hot Flashes
- \_\_\_ 625.3 Cramps or Backaches
- \_\_\_ 623.5 Vaginal Discharge
- \_\_\_ Pregnant at this Time
- \_\_\_ Last Pap
- By Whom \_\_\_\_\_
- Other \_\_\_\_\_

**IN PATIENT / OUT PATIENT OPERATIONS AND PROCEDURES - HOSPITALIZATION**

DATE	DATE	DATE	DATE
_____ Vaccinations	_____ Other	_____ Rectal Surgery	_____ Thyroid
_____ Tonsillectomy	_____ Tubes in Ears	_____ Other	_____ Stomach
_____ Gall Bladder	_____ Appendectomy	_____ Sinus	_____ Other
_____ Back Operation	_____ Female Organs	_____ Hernia	

Hospital Stays \_\_\_\_\_  
 Other Surgeries \_\_\_\_\_

Have you ever had any accidents or falls of any kind? List dates:  Car \_\_\_\_\_  Recreational Vehicle \_\_\_\_\_  
 Sports \_\_\_\_\_  School \_\_\_\_\_  Other \_\_\_\_\_

List any broken bones (fractures) or dislocations: \_\_\_\_\_

Have you ever been on crutches?  Yes  No Why? \_\_\_\_\_

Have you ever had a lapse of memory?  Yes  No Have you ever been unconscious?  Yes  No

Have you ever had X-rays taken?  Yes  No When? \_\_\_\_\_ By Whom? \_\_\_\_\_

For what ailments were these X-rays made? \_\_\_\_\_

Do you suffer from any condition other than that for which you are now consulting us? \_\_\_\_\_

Are you presently taking any medication - prescription or over-the-counter?  Yes  No List: \_\_\_\_\_

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to examine and treat my condition as he/she deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed the amount paid the Doctor for x-rays is for examination only and the x-ray negatives will remain the property of this office, being on file where they may be seen at any time while I am an active patient in this office. The patient also agrees that he/she is responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. Patient may obtain copies of their file and x-rays upon request. Copying fees may apply.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor Signature \_\_\_\_\_ Date \_\_\_\_\_