**PLEASE ANSWER ALL QUESTIONS AS COMPLETELY AS POSSIBLE**

Describe your areas of complaint(s): List everywhere you hurt or have symptoms in order of importance. (The doctor will also make additions.)

_____

_____

_____

What caused your most recent symptoms?

_____

When did your present symptoms begin?

_____

Is this condition getting: Better _____ Worse _____ Staying the same _____ Other

_____

When are your symptoms worse? Morning _____ Afternoon _____ Evening _____ Night _____ Other

_____

What movements or positions aggravate your condition?

_____

What relieves your symptoms?

_____

Have you been treated for this recent condition? Yes _____ Date _____ No ____ Name of Dr._____

What was done?

_____

Describe your work:_____

How has this problem(s) affected you and your life?_____

Have you missed any work? _____ If yes, when?_____

Have you ever had a similar condition before? Yes _____ Date_____ No _____

Explain_____

_____

List all previous injuries or accidental falls and date(s) (including back pain)_____

List all previous operations and date(s)_____

List major illness (es) and date (s)_____

List present medications (prescription and non-prescription)_____

List all nutritional supplements_____

List any athletic activity or exercise_____

Previous Chiropractic care? Yes ____ Date _____ No ____ If yes Dr.?_____

CHECK THE FOLLOWING WHICH YOU HAVE HAD AND UNDERLINE ANY YOU HAVE NOW

**GASTRO-INTESTINAL**
Constipation
Diarrhea
Digestive Problems
Stomach Pain
Gall Bladder Trouble
Hemorrhoids
Liver Trouble
Hernia
Vomit of Blood

**SKIN**
Boils
Bruising
Dryness

**GENITO-URINARY**
Frequent Urination
Painful Urination
Difficulty Start Urine
Inability to Control Urine
Blood in Urine
Bed Wetting
Kidney Infection
Prostate Trouble

**CARIO VASCULAR**
High Blood Pressure
Spiting of Blood
Chest Pains
Low Blood Pressure
Previous Heart Trouble
Previous Stroke

**RESPIRATORY**
Chronic Cough
Difficulty Breathing
Nose Bleeds
Sinus Trouble
Asthma

**EYES-EARS-NOSE**
Earaches
Ear Discharge
Hard to Swallow
Nasal Discharge
Eye Pains

**MUSCLES-JOINTS**
Swollen Joints

**GENERAL**
Frequent Colds
Ringing in Ears
Cramps-Backache
Allergies
Weight Loss
Nervousness
Hoarseness
Foot Problems
Emotional Problems

**WOMEN ONLY**
Excessive Flow
Hot Flashes
Irregular Cycles
Painful Intercourse
Painful Menstruation

Date of Last: Spinal Examination_____ Spinal X-ray_____ Blood Test_____ Urine Test_____
Physical Exam_____ Chest X-ray_____ Have you ever tested positive for HIV/AIDS?_____
Signature _____ Print Name_____ Date_____