

Is there anything you do that makes your condition worse? _____

How has this condition affected your life?

- A. Home life _____
- B. Occupational life _____
- C. Recreational life _____
- D. Rest and Sleep life _____

Check the box if you have had any of these symptoms.

- | | | | | |
|---|---|--|---|---|
| <input type="checkbox"/> recent weight change | <input type="checkbox"/> weakness / fatigue | <input type="checkbox"/> fever | <input type="checkbox"/> chills | <input type="checkbox"/> night sweats |
| <input type="checkbox"/> tinnitus | <input type="checkbox"/> hearing loss | <input type="checkbox"/> vertigo | <input type="checkbox"/> dizziness | <input type="checkbox"/> double or blurred vision |
| <input type="checkbox"/> joint swelling | <input type="checkbox"/> cramps | <input type="checkbox"/> arthritis | <input type="checkbox"/> gout | |
| <input type="checkbox"/> palpitations | <input type="checkbox"/> chest pain | <input type="checkbox"/> cough | <input type="checkbox"/> difficulty breathing | |
| <input type="checkbox"/> loss of appetite | <input type="checkbox"/> nausea / vomiting | <input type="checkbox"/> bowel problems | <input type="checkbox"/> bladder problems | |
| <input type="checkbox"/> thyroid | <input type="checkbox"/> diabetes | <input type="checkbox"/> excessive thirst / hunger | <input type="checkbox"/> insomnia | |
| <input type="checkbox"/> coldness | <input type="checkbox"/> anemia | <input type="checkbox"/> depression | <input type="checkbox"/> nervous | <input type="checkbox"/> anxious |

Have you ever been in an automobile accident? Past year Past 5 years Over 5 years Never

ANY ACCIDENTS, FALLS, ECT., THAT MIGHT HAVE CAUSED YOUR PROBLEM _____

ANY MEDICAL DIAGNOSIS OF YOUR COMPLAINT _____

What surgeries has been done? _____

DRUG YOU NOW TAKE: Nerve Pills Muscle Relaxers "Pep" Pills Tranquilizers Insulin
 Birth Control Pills Other (please list) _____

Over the counter medication/ vitamins / supplements you take. _____

ANY CHIROPRACTOR CONSULTED IN THE PAST? Name: _____

Dates consulted: _____ For what problem? _____

Fees are payable at the time of x-rays, examinations, and treatments are received, unless other arrangements are made in advance. X-rays remain the property of the clinic.

Patient's Signature _____ Date _____

- I would like to sign up for a **Free** bi-monthly health electronic newsletter. Learn about back pain, exercise and nutrition. Your email address will not be given or sold to anyone.

Email _____

- No thanks, I would prefer not to receive your newsletter.