

Below is a list of conditions which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can effect your overall diagnosis, treatment plan, and possibility of being accepted for care. Please enter 1 (Never), 2 (Occasionally), 3 (Presently) in front of all the following signs and symptoms. A complete history and understanding of your health status will facilitate care.

<b>GENERAL SYMPTOMS</b>		<b>GASTRO-INTESTINAL</b>		<b>EYE EAR NOSE THROAT</b>		<b>RESPIRATORY</b>	
___ 784.0	Headache	___ 783	Poor Appetite	___ 368.9	Poor vision	___ 786.2	Chronic Cough
___ 780.6	Fever	___ 536.8	Poor Digestion	___ 378.9	Crossed Eyes	___ 786.3	Spitting Blood
___ 780.9	Chills	___ 994.2	Excessive Hunger	___ 379.91	Pain in Eyes	___ 933.1	Spitting Phlegm
___ 780.8	Night Sweats	___ 787.3	Belching or Gas	___ 389.9	Deafness	___ 786.50	Chest Pain
___ 780.2	Fainting	___ 787	Nausea	___ 388.70	Earache	___ 786.09	Difficulty Breathing
___ 780.4	Dizziness	___ 787	Vomiting	___ 388.30	Ear Noises		
___ 780.3	Convulsions	___ 578	Vomiting Blood	___ 388.60	Ear Discharges		
___ 780.52	Loss of Sleep	___ 536.8	Pain Over Stomach	___ 478.1	Nasal Obstruction	<b>GENITO—URINARY</b>	
___ 780.7	Fatigue	___ 564	Constipation	___ 784.7	Nose Bleeds	___ 788.3	Frequent Urination
___ 799.2	Nervousness	___ 558.9	Diarrhea	___ 462	Sore Throat	___ 788.1	Painful Urination
___ 783	Loss of Weight	___ 789	Colon Trouble	___ 784.49	Hoarseness	___ 599.7	Blood in Urine
___ 782	Numbness or Pain in	___ 455.6	Hemorrhoids (Piles)	___ 477.9	Hay Fever	___ 592	Kidney Infection
	arms/legs/hands	___ 785.1	Liver Trouble	___ 493.9	Asthma	___ 788.3	Bed Wetting
___ 995.3	Allergy (What)	___ 782.4	Jaundice	___ 460	Frequent Colds	___ 788.1	Inability to Control Urine
___ 786.09	Wheezing	___ 575.9	Gall Bladder Trouble	___ 240.9	Enlarged Thyroid	___ 601.9	Prostrate Trouble
___ 729.2	Neuralgia			___ 463	Tonsillitis		
				___ 686.9	Sinus Trouble		
<b>MUSCLE &amp; JOINTS</b>		<b>CARDIO-VASCULAR</b>		<b>SKIN OR ALLERGIES</b>		<b>FOR WOMEN ONLY</b>	
___	Weakness	___ 783	Rapid Heart	___ 368.9	Skin Eruptions	___ 786.2	Painful Periods
___	Twitching	___ 427.89	Slow Heart	___ 698.9	Itching	___ 626.2	Excessive Flow
___ 847	Stiff Neck	___ 401.9	High Blood Pressure	___ 287.8	Bruising Easily	___ 626.4	Irregular Cycles
___ 722.10	Backache	___ 458.9	Low Blood Pressure	___ 701.1	Dryness	___ 627.2	Hot Flashes
___ 719	Swollen Joints	___ 786.51	Pain Over Heart	___	Boils	___ 625.3	Cramps or Backache
___ 781	Tremors	___ 438	Prev. Heart Trouble	___ 782	Sensitive Skin	___ 634.9	Miscarriage
___ 729.5	Foot Troubles	___ 719.07	Swelling of Ankles	___ 708.9	Hives or Allergy	___ 623.5	Vaginal Discharge
___ 724.79	Painful Tail Bone	___ 459.9	Poor Circulation	___ 692.9	Eczema	___	Pregnant at this time
___ 724.5	Pain Between Shoulders	___ 436	Varicose Veins	___	Medicines	___	Last Pap
___ 553.9	Hernia		Strokes				
___ 737.3	Spinal Curvature						
						By Who: _____	
						Other: _____	

<b>HABITS</b>		<b>EXERCISE</b>		<b>FAMILY HISTORY</b>					
___	Smoking ___pks/day___	___	None		<b>Diabetes</b>	<b>Heart</b>	<b>Kidney</b>	<b>Cancer</b>	<b>Back</b>
___	Drinking ___Alcohol___	___	Moderate	Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
___	Coffee ___cups/day___	___	Daily	Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Brother No. of _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Sister No. of _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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 treat my condition as he deems appropriate through the use of manipulation throughout my spine. 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 a patient of 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's Signature **X** \_\_\_\_\_ S.S. # \_\_\_\_\_ DATE \_\_\_\_\_

Guardian or Spouse's Signature Authorizing Care \_\_\_\_\_ DATE \_\_\_\_\_