

YOUR CONDITION

Reason For Today's Visit: _____

When Did Your Symptoms First Appear? _____

Is This Condition Getting : Worse Better Staying the Same

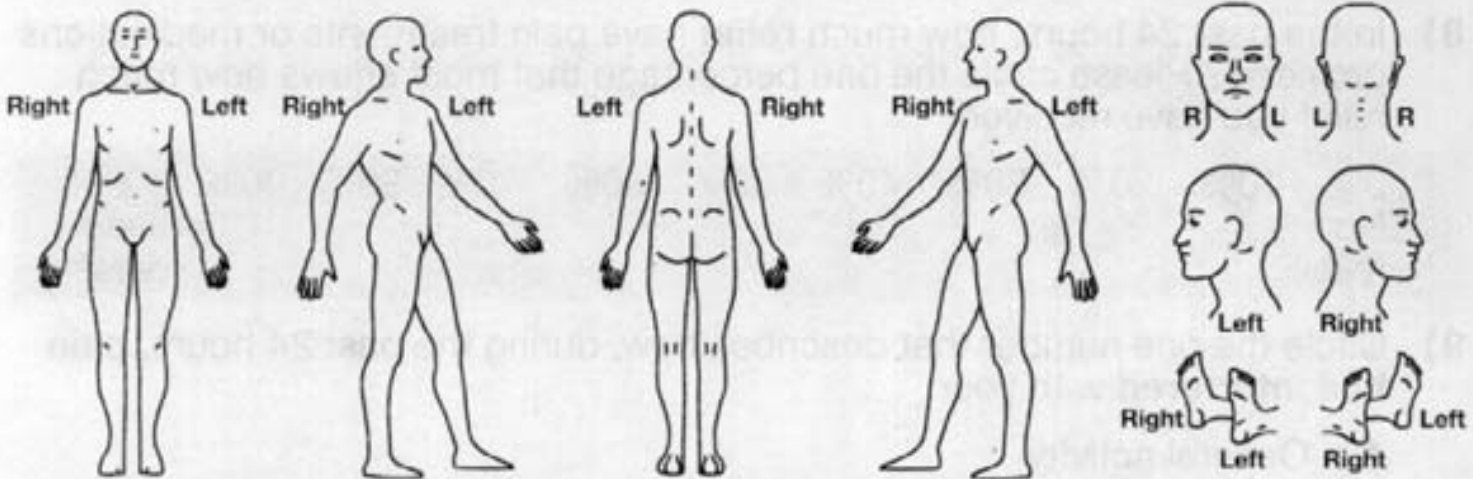
Rate Your Pain On A Scale Of 1 (least pain) to 10 (most severe pain): _____

How Often Do You Get This Pain? _____ Is It Constant? _____

Type Of Pain: Sharp Dull Throbbing Numbness Aching Shooting
 Burning Tingling Cramps Stiffness Swelling Stabbing Other

Does The Pain Interfere with Your: Work Daily Routine Recreation

Activities That Are Painful To Perform: Sitting Standing Walking Bending Lying Down



**** MARK YOUR PROBLEM AREAS ON THE DIAGRAMS ABOVE ****
 USING AN "X" TO MARK THE SPOT !

HEALTH HISTORY

What Treatment Have You Already Received For Your Condition? Medications Surgery Chiropractic
 Physical Therapy None Other _____

Name of Other Doctor(s) Who Have Treated You For This Condition: _____

Date Of Last: Physical Exam: _____ Spinal X-Ray: _____

Blood Test: _____ Chest X-Ray: _____

Spinal Exam: _____ CT-Scan, MRI, Bone Scan: _____

List Location Of Lab Work Or Radiology Services: _____

Check The Box If You Have **OR** Have Had Any Of The Following:

- | | | | |
|--|---|--|--|
| AIDS/HIV <input type="checkbox"/> | Chicken Pox <input type="checkbox"/> | Low Back Pain <input type="checkbox"/> | Rheumatic Fever <input type="checkbox"/> |
| Alcoholism <input type="checkbox"/> | Diabetes <input type="checkbox"/> | Lung Disease <input type="checkbox"/> | Scarlet Fever <input type="checkbox"/> |
| Allergy Shots <input type="checkbox"/> | Emphysema <input type="checkbox"/> | Measles <input type="checkbox"/> | Spinal Disorders <input type="checkbox"/> |
| Anemia <input type="checkbox"/> | Epilepsy <input type="checkbox"/> | Migraines <input type="checkbox"/> | Stomach Disorders <input type="checkbox"/> |
| Anorexia <input type="checkbox"/> | Eye Disease <input type="checkbox"/> | Mononucleosis <input type="checkbox"/> | Stroke <input type="checkbox"/> |
| Appendicitis <input type="checkbox"/> | Fractures <input type="checkbox"/> | M.S. <input type="checkbox"/> | Thyroid Problems <input type="checkbox"/> |
| Arthritis <input type="checkbox"/> | Gall Bladder <input type="checkbox"/> | Mumps <input type="checkbox"/> | Tonsillitis <input type="checkbox"/> |
| Asthma <input type="checkbox"/> | Disease <input type="checkbox"/> | Nerve Disorder <input type="checkbox"/> | Tuberculosis <input type="checkbox"/> |
| Bleeding Disorder <input type="checkbox"/> | Glaucoma <input type="checkbox"/> | Osteoporosis <input type="checkbox"/> | Tumors / Growths <input type="checkbox"/> |
| Bladder Disease <input type="checkbox"/> | Gout <input type="checkbox"/> | Pace Maker <input type="checkbox"/> | Typhoid Fever <input type="checkbox"/> |
| Bone Disease <input type="checkbox"/> | Headaches <input type="checkbox"/> | Parkinson's <input type="checkbox"/> | Ulcers <input type="checkbox"/> |
| Bowel Disorder <input type="checkbox"/> | Heart Disease <input type="checkbox"/> | Disease <input type="checkbox"/> | Whooping Cough <input type="checkbox"/> |
| Bronchitis <input type="checkbox"/> | Herniated Disc <input type="checkbox"/> | Pneumonia <input type="checkbox"/> | Other: _____ |
| Bulimia <input type="checkbox"/> | Hernia <input type="checkbox"/> | Polio <input type="checkbox"/> | _____ |
| Cancer <input type="checkbox"/> | High Cholesterol <input type="checkbox"/> | Prostate Issues <input type="checkbox"/> | _____ |
| Cataracts <input type="checkbox"/> | Hypertension <input type="checkbox"/> | Prosthesis <input type="checkbox"/> | _____ |
| Chemical <input type="checkbox"/> | Kidney Disease <input type="checkbox"/> | Rheumatoid <input type="checkbox"/> | _____ |
| Dependencies <input type="checkbox"/> | Liver Disease <input type="checkbox"/> | Arthritis <input type="checkbox"/> | _____ |