**Naturally Chiropractic**

*If you've had a listed condition in the past, please check it in the Past column. If you are presently troubled by a condition, check it in the Present column. The info. you provide assists your doctor in more thoroughly understanding your state of health.*

**Weight:** ________ **Height:** ___________

**Medications:** ________________________________________________________________________________

**Hospitalization/Surgical Procedures:** ____________________________________________________________

| Past | Present | Condition | Past | Present | Condition |
|---|---|---|---|---|---|
| | | Neck Pain | | | Depression |
| | | Shoulder Pain | | | Aortic Aneurysm |
| | | Upper Arm/Elbow Pain | | | High Blood Pressure |
| | | Hand Pain | | | Angina |
| | | Wrist Pain | | | Heart Attack |
| | | Upper Back Pain | | | Stroke |
| | | Low Back Pain | | | Asthma |
| | | Upper Leg/Hip Pain | | | Cancer |
| | | Lower Leg/Knee Pain | | | Tumor |
| | | Ankle/Foot Pain | | | Prostate Problems |
| | | Jaw Pain | | | Anorexia |
| | | Swelling/Stiffness of Joint(s) | | | Blood Disorder |
| | | Fainting | | | Chronic Lung Disorder(s) |
| | | Visual Disturbances | | | Arthritis |
| | | Convulsions | | | Rheumatoid Arthritis |
| | | Dizziness | | | Diabetes |
| | | Headache | | | Epilepsy |
| | | Muscular Incoordination | | | Ulcer |
| | | Tinnitus (Ear Noises) | | | Liver/Gallbladder Problems |
| | | Rapid Heart Beat | | | Kidney Stones |
| | | Chest Pains | | | Hepatitis |
| | | Loss of Appetite | | | Bladder Infection |
| | | Abnormal Weight Gain | | | Abnormal Weight Loss |
| | | Kidney Disorders | | | Colitis |
| | | Excessive Thirst | | | Irritable Colon |
| | | Chronic Cough | | | HIV/AIDS |
| | | Chronic Sinusitis | | | General Fatigue |
| | | Irregular Menstrual Flow | | | Profuse Menstrual Flow |
| | | Breast Soreness/Lumps | | | Endometriosis |
| | | PMS | | | Loss of Bladder Control |
| | | Painful Urination | | | Frequent Urination |
| | | Abdominal Pain | | | Constipation/Irregular Bowel Habits |
| | | Difficulty Swallowing | | | Heartburn/Indigestion |
| | | Dermatitis/Eczema/Rash | | | Tobacco |
| | | Pregnancy | | | Alcohol |
| | | Birth Control Pills | | | Drug/Alcohol Dependence |

**If you have a permanent disability rating:** Location: ______________________________________________

Date rating received: ____/____/______ Rating Percentage: ___________%

**Coffee/Tea/Caffeinated Soft Drinks consumed per day:** ___________

**Has a family member had any of the following?**

| | | | |
|---|---|---|---|
| Cancer | Rheumatoid Arthritis | Epilepsy | Diabetes |
| Chronic Back Problems | Chronic Headaches | Heart Problems | Lung Problems |
| Lupus | High Blood Pressure | | |

**Patient Signature:** ______________________________________________________ **Date:** ____/____/______