Name_____ Today's Date _____

Chief Complaint: _____

Is it *localized* or does it *travel*?   Is it *constant* or *intermittent*?   *Please Circle*

If intermittent, when was the last time felt?_____

Does anything make it better?_____

Does anything make it worse?_____

Please *circle* the description below that best describes your discomfort.
_____

Ache Burning Numbness Pins Stabbing

Dull Sharp Shooting Throbbing Stiff/Tight

Circle the level of your symptoms BEFORE today's treatment.

< 1 2 3 4 5 6 7 8 9 10 >

Above, mark the location of your symptoms and draw an arrow to indicate the path if it travels.

Is this condition worse during certain times of the day?_____

Is this condition interfering with work? _____Sleep? _____Routine? _____Other? _____

Is this condition progressively getting worse?_____

Previous interventions, treatments, medications, surgery, or care you've sought for your complaint?

_____

_____

Please answer the following and if your answer is Yes, give brief details:

Did/do you smoke?	Y N	_____
Did/do you drink alcohol?	Y N	_____
Did/do you have occupational stress?	Y N	_____
Physical stress?	Y N	_____
Emotional/Mental stress?	Y N	_____
Allergies	Y N	_____
Sleeping posture? O side O stomach	O back	

Previous illnesses you've had in your life: _____

_____

Previous injury or trauma (please include any automobile or work-related accident: _____

_____

Have you ever broken any bones? Which? _____

Patient Name_____ **Date** _____

Please check each box that applies. Note the duration and the last time you had this symptom.

Cardiovascular/Vertebrobasilar/Respiratory/Gastrointestinal Systems

❑ General swelling	❑ Irregular heart beat	❑ Shortness of breath
❑ Swelling in legs	❑ Hardening of the arteries	❑ Can't breathe while lying down
❑ Swelling in face	❑ Areas of muscle weakness	❑ Can't sleep while lying down
❑ Swelling around eyes	❑ Dizziness with nausea	❑ Dry cough
❑ Chest pain	❑ Dizziness without nausea	❑ Productive cough
❑ Pounding heart beat	❑ Blurred vision	❑ Coughing up blood
❑ Heart "jumps"	❑ Fainting spells	❑ Poor appetite
❑ Rapid heart beat	❑ Stroke	❑ Constant nibbling
❑ Blue or purple skin	❑ Diabetes	❑ Difficulty in swallowing
❑ Blue or purple nailbeds	❑ Pain over the heart	❑ Indigestion
❑ Fainting	❑ Cold hands and/or feet	❑ Nausea and vomiting
❑ Hypertension	❑ Areas of numbness	❑ Jaundice
❑ Double vision	❑ Arthritis	❑ Abdominal pain
❑ Loss of coordination	❑ Previous neck or head injury	❑ Change in bowel habits
❑ Irregular muscle movement	❑ Loss of memory	❑ Diarrhea
❑ Ringing in ears	❑ Inability to form words	❑ Constipation
❑ Heart attack	❑ Periods of blindness in one eye	❑ Hemorrhoids
❑ Cancer	❑ Blood vessel disease (phlebitis, etc.)	❑ Stomach upset
❑ Stroke	❑ Asthma	❑ Tension
❑ Depression	❑ Fatigue	❑ Weight loss
❑ Rheumatic fever	❑ Anemia	❑ Epilepsy
❑ Hypoglycemia	❑ Multiple sclerosis	❑ Parkinson's disease
❑ Polio	❑ Tuberculosis	❑ HIV/AIDS
❑ Irritability	❑ Nervousness	❑ Sleeping problems

Musculoskeletal System

❑ Unusually frequent headache	❑ Pain in shoulders R L	❑ Pain between shoulder blades
❑ Unusually severe headache	❑ Pain across shoulders	❑ Sharp stabbing pain in mid back
❑ Head feels heavy	❑ Tension in shoulders R L	❑ Dull ache in mid back
❑ Vertigo	❑ Muscle spasms in shoulders R L	❑ Pain from front to back
❑ Light-headedness	❑ Can't raise arm above shoulder level	❑ Pain over kidney area
❑ Loss of smell	❑ Can't raise arm over head R L	❑ Muscle spasms in mid back
❑ Loss of taste	❑ Pain in upper arm R L	❑ Low back pain
❑ Loss of balance	❑ Pain in forearm R L	❑ Low back feels out of place
❑ Dizziness	❑ Pain in hands R L	❑ Muscle spasms in low back
❑ Pain in neck	❑ Pain in fingers R L	❑ Pain in buttocks
❑ Neck pain with movement	❑ Pins & needles in arms R L	❑ Pain down leg R L
❑ Swelling in neck	❑ Pins & needles in fingers R L	❑ Knee pain R L
❑ Stiff neck	❑ Fingers go to sleep R L	❑ Leg cramps R L
❑ Pinched nerve in neck	❑ Hands cold R L	❑ Pins & needles in legs R L
❑ Neck feels out of place	❑ Swollen joints in fingers R L	❑ Numbness in leg R L
❑ Grinding sound in neck	❑ Sore joints in fingers R L	❑ Cold feet R L
❑ Popping sound in neck	❑ Loss of grip strength R L	❑ Swollen ankles R L
❑ Limited neck movement	❑ Mid-back pain	❑ Swollen feet R L
❑ Spasms in neck		

Skin/Hair/Nails/Eyes/Ears/Nose/Nasopharynx/Sinuses/Mouth and Throat/Genitourinary/Venereal Disease/Other

❑ Eczema	❑ Loss of hearing	❑ Abscessed teeth
❑ Itchy skin	❑ Pain in ears	❑ Dentures
❑ Dry scalp	❑ Discharge from ears	❑ Difficulty swallowing
❑ Oily scalp	❑ Vertigo	❑ Changes in voice
❑ Rough, scaly skin	❑ Ringing in ears	❑ Urination is frequent
❑ Oily skin	❑ Unusual nasal discharge	❑ Urination is normal
❑ Dry skin	❑ Nose bleeds	❑ Urination is infrequent
❑ Psoriasis	❑ Pressure over eyes	❑ The amount of urination is high
❑ Yellow skin	❑ Pressure under eyes	❑ The amount of urination is normal
❑ Bruise easily	❑ Obstruction of nose	❑ The amount of urination is low
❑ Paper thin nails	❑ Frequent colds	❑ Need to get up at night to urinate
❑ Pale skin	❑ Sinusitis	❑ Abnormal intense desire to urinate
❑ Nail biting	❑ Nasal allergies	❑ Difficulty starting urination
❑ Baldness	❑ Loss of sense of smell	❑ Decreased output
❑ Blurring of vision	❑ Any trauma to nose	❑ Pain upon urination
❑ Double vision	❑ Pain of mouth	❑ Dribbling
❑ Eyes fatigue easily	❑ Pain of throat	❑ Blood in urine
❑ Excessive tearing	❑ Bleeding gums	❑ Cloudy urine
❑ Lack of tearing	❑ Cavities	❑ Lack of bladder control
❑ Light bothers eyes	❑ Loss of sense of taste	❑ Abdominal pain
❑ Excessive itching	❑ Crave sweets	❑ Syphilis
❑ Pain in eyeball	❑ Crave salt	❑ Gonorrhea

Current Medications   **Reason for taking**

_____   _____

_____   _____

_____   _____

Surgeries:
Date   Type of Surgery

_____   _____

_____   _____

_____   _____

Females:
Pregnancies/Date of Delivery   Outcome

_____   _____

_____   _____

_____   _____

What was the date of the beginning of your last menstrual period? _____Do you have painful periods? ___ Yes ___ No
Do you have premenstrual symptoms? ___ Yes ___ No   Do you have vaginal discharge? ___ Yes ___ No
Do you have spotting? ___ Yes ___ No   Do you have irregular periods? ___ Yes ___ No
Do you have menstrual cramps? ___ Yes ___ No   Do you have lumps in your breasts? ___ Yes ___ No

Family Health History:
Associated health problems of relatives: _____

_____
Deaths in immediate family:
Cause of parents or siblings death   Age at death
_____   _____

_____   _____

_____   _____

Children's Names and Ages:_____

Social and Occupational History:
Job description: _____

Work schedule: _____

Recreational activities: _____

Lifestyle (hobbies, level of exercise, diet):_____

PATIENTS NEED TO BE AWARE:
- Services that are not covered by insurance and must be paid in full at the time of rendering are Avatar testing, Bio-Ray treatments, IV chelation therapy, supplements, and consults by the doctor that are not nutritional or spinal in nature.
- We ask our patients to give us 24 hours notice of an appointment cancellation. With discretion, we reserve the right to charge for the time allotted for these appointments if proper notice was not given.

I have read the information on these pages and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of to provide me with care, in accordance the doctor's licensures and with this state's statutes.

Patient or Parent/Guardian Signature _____ Date _____CaseHistory.doc