

Yes	No	3. Current Health Habits	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Did/do you smoke?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Did/do you drink any alcohol?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Diet (Do you eat healthy foods?)	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Have you been in accidents?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Have you had surgery and organs removed/replaced?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Drugs? (Prescriptive or non-prescriptive)	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Teeth problems?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Eye problems?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Hearing problems?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Exercise regularly?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Sleeping habits (nightmares?)	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Did/do you have occupational stress?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Physical stress?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Mental stress?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Hobbies/Sports injuries?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Sleeping posture <input type="checkbox"/> side <input type="checkbox"/> stomach <input type="checkbox"/> back	_____	_____

Symptoms and Ill Health (Present State of Ill Health)

Finally, the years of continuing damage showed up as acute or chronic symptoms.

Present Complaint (be brief)

Major _____

Pain or Problem started on _____

Pains are: Sharp Dull Constant Intermittent

What activities aggravate your condition/pain? _____

What activities lessen your condition/pain? _____

Is condition worse during certain times of the day? _____

Is this condition interfering with work? _____ Sleep? _____ Routine? _____ Other? _____

Is condition getting progressively worse? _____

Other Doctors seen for this condition _____

Any home remedies? _____

Other symptoms:

- | | | |
|--|---|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Pins & Needles in Legs | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Pins & Needles in Arms | <input type="checkbox"/> Loss of Smell |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Numbness in Fingers | <input type="checkbox"/> Loss of Taste |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Numbness in Toes | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Feet Cold |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Hands Cold |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Depression | <input type="checkbox"/> Stomach Upset |
| <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Lights Bother Eyes | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Cold Sweats |
| <input type="checkbox"/> Face Flushed | <input type="checkbox"/> Ears Ring | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Neck Stiff | <input type="checkbox"/> Fever | <input type="checkbox"/> Buzzing in Ears |

Have you been under drug and medical care? _____

What medications are you taking? _____

How Long? _____ Have you had surgery? _____ What? _____ When? _____

What side effects have you experienced from the drugs and surgery? _____

Is there a family history of:

	Heart Disease	Arthritis	Cancer	Diabetes	Other
Father's side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mother's side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

About Your Care

Chiropractic provides three types of care. The first is **Initial Intensive Care** which corrects the most recent layer of Spinal and Neurological damage (VSC). This care usually reduces or eliminates the symptoms. Then begins **Reconstructive Care** which corrects the years of damage that occurred when there were few symptoms. And finally, Chiropractic offers a genuine approach to **Wellness Care**. All of these options will be explained at your report of findings. Then you'll be able to begin a course of care that fits your health goals.