Patient Name: _____

Date of Birth: _____

Patient Signature: _____

Date: _____

Please Answer all Questions as Past or Present

General

Weight Loss	Yes	No
Weight Gain	Yes	No
Fever	Yes	No
Weakness	Yes	No
Trouble Sleeping	Yes	No
Fatigue	Yes	No
Hernia	Yes	No
Type_____		
Bed Wetter	Yes	No
Sleep Walker	Yes	No
Hernia	Yes	No
Type_____		
Operations	Yes	No
Type_____		
Radiation Exposure	Yes	No
Unusual Pets	Yes	No
Type_____		
Work w/ Chemicals	Yes	No

Head

Frequent Headaches	Yes	No
Head Injury	Yes	No
Concussion	Yes	No
Dizziness	Yes	No
Knocked Unconsciuos	Yes	No
Twitching in Face	Yes	No
Head or Shoulders		
Pressure	Yes	No

Skin

Rashes	Yes	No
Lumps	Yes	No
Itching	Yes	No
Dryness	Yes	No
Color Changes	Yes	No
Hair/Nail Changes	Yes	No
Tender/Sensitive	Yes	No
Flushing of Skin	Yes	No
Skin Conditions	Yes	No
Please Explain_____		
Extended Healing		
Time for Wounds	Yes	No

Nose

Runny Nose	Yes	No
Congested	Yes	No
Nose Bleeds	Yes	No
Discharge	Yes	No
Itchy	Yes	No
Sinus Pain	Yes	No
Frequent Colds	Yes	No
Severe Colds	Yes	No
Sinus Condition	Yes	No
Hay Fever	Yes	No

Throat

Clear Throat Often	Yes	No
Sore Throat	Yes	No
Hoarseness	Yes	No
Difficulty or Pain Swallowing	Yes	No
Tonsils Removed	Yes	No

Cardiovascular

Chest Pain	Yes	No
Tightness	Yes	No
Palpitations	Yes	No
Shortness of Breath	Yes	No
Difficulty Breathing	Yes	No
Swelling	Yes	No
Chest X-Ray	Yes	No
EKG	Yes	No
Heart Attack	Yes	No
Angina	Yes	No
Heart Trouble in Family	Yes	No
Stress Test	Yes	No
Shortness of Breath at Night	Yes	No
Daily Exercise	Yes	No
High Blood Pressure	Yes	No
Low Blood Pressure	Yes	No
Racing Heart	Yes	No
High Cholesterol	Yes	No
Heart Valve Problems	Yes	No
Heart Murmur	Yes	No
Regular Aspirin Use	Yes	No

Ears

Decreased Hearing	Yes	No
Ringing in Ears	Yes	No
Earache	Yes	No
Drainage	Yes	No
Hearing Aid	Yes	No

Mouth

Dentures	Yes	No
Gums Bleeding	Yes	No
Thrush	Yes	No
Non-Healing Sores	Yes	No
Sore Tongue	Yes	No
Routine Antibiotics for Dental Work	Yes	No
Sores on Lips	Yes	No

Last Dental Exam _____

Respiratory

Respiratory	Yes	No
Cough	Yes	No
Constant Cough	Yes	No
Coughing up Blood	Yes	No
Shortness of Breath	Yes	No
Wheezing	Yes	No
Painful Breathing	Yes	No
Sputum	Yes	No
Bronchtis	Yes	No
Pneumonia	Yes	No
Smoker	Yes	No
Difficulty Breathing	Yes	No
Rheumatic Fever	Yes	No

Immune

Immune	Yes	No
Frequently Ill	Yes	No
Auto Immune Disease Type_____	Yes	No
Poor Health Run In Family	Yes	No

Gastrointestinal

Colitis	Yes	No
Irritable Bowel System	Yes	No
Heartburn	Yes	No
Change in Appetite	Yes	No
Change in Bowel Movements	Yes	No
Nausea	Yes	No
Rectal Bleeding	Yes	No
Constipation	Yes	No
Hemmorhoids	Yes	No
Diarrhea	Yes	No
GI X-Rays/Ultrasound	Yes	No
Barium Enema X-Ray	Yes	No
Gallstones	Yes	No
Proctoscopy	Yes	No
Dysentery	Yes	No
Appendicitis	Yes	No
Ulcer	Yes	No
Abdominal Surgery	Yes	No
Jaundice	Yes	No

Eyes

Glasses or Contacts	Yes	No
Pain in Eyes	Yes	No
Redness	Yes	No
Blurry Vision	Yes	No
Double Vision	Yes	No
Specks in Vision	Yes	No
Glaucoma	Yes	No
Cataracts	Yes	No
Near Sighted	Yes	No
Far Sighted	Yes	No
Watering of Eyes	Yes	No
Excessive Blinking	Yes	No

Neck

Lumps	Yes	No
Swollen Glands	Yes	No
Pain	Yes	No
Stiffness	Yes	No
Goiter in Neck	Yes	No

MuscoSkeletal/Skeletal

Broken Bones	Yes	No
Weak/Brittle Bones	Yes	No
Muscle or Joint Pain	Yes	No
Stiffness	Yes	No
Back Pain	Yes	No
Swelling of Joints	Yes	No
Redness of Joints	Yes	No
Arthritis	Yes	No
Type_____	Yes	No
Swollen Joints	Yes	No
Joint Pain	Yes	No
Pains in Arms/Legs/Feet	Yes	No
Any Difformities	Yes	No
Type_____	Yes	No
Seen a Chiropractor	Yes	No
Regular Exercise	Yes	No

Hematologic

Ease of Bruising	Yes	No
Ease of Bleeding	Yes	No
Blood Transfusion	Yes	No
Donate Blood	Yes	No

Vascular

Calf Pain w/ Walking	Yes	No
Claudication	Yes	No
Leg Cramping	Yes	No
Swollen Ankles	Yes	No
Water Pills	Yes	No
Vericose Veins	Yes	No

Sleep

Sleeping Pills	Yes	No
Walking in Your Sleep	Yes	No
Sedatives/Tranquilzers	Yes	No
Trouble Falling Asleep	Yes	No
Frequent Bad Dreams	Yes	No

Urinary	Yes	No
Frequency	Yes	No
Urgency	Yes	No
Waking to Urinate	Yes	No
Incontinence	Yes	No
Change in Urinary Strenth	Yes	No
Frequent Urination	Yes	No
Trouble Urinating	Yes	No
Kidney Disease	Yes	No
Kidney Stones	Yes	No
Bladder Disease	Yes	No
Blood In Urine	Yes	No
Burning or Pain	Yes	No
Frequent UTI's	Yes	No

Endocrine		
Sensitive to	Yes	No
Heat or Cold	Yes	No
Intolerances	Yes	No
Sweating	Yes	No
Cold Sweats	Yes	No
Night Sweats	Yes	No
Increased Appetite	Yes	No
Increased Thirst	Yes	No

Illnesses	Yes	No
Malaria	Yes	No
Scarlet Fever	Yes	No
Anemia		
Diabetes	Yes	No
Type_____	Yes	No
Cancer	Yes	No
Type_____	Yes	No
Hypoglycemia		
Thyroid Condition		
Type_____		

Neurological		
Dizziness	Yes	No
Fainting	Yes	No
Times_____	Yes	No
Seizures	Yes	No
Weakness	Yes	No
Numbness	Yes	No
Tingling	Yes	No
Tremors	Yes	No
Twitching	Yes	No
Convulsions	Yes	No
Epilepsy	Yes	No
Stuttering/Stammering	Yes	No

Psychiatric		
Nervousness	Yes	No
Depression/Unhappy	Yes	No
Memory Loss	Yes	No
Stress	Yes	No
Trouble Sleeping	Yes	No
Worry	Yes	No
Mentally Worn Out	Yes	No
Nervous Breakdown	Yes	No
Sought Counseling/Treatment	Yes	No
Type_____		
Cry a lot	Yes	No
Shy/Sensitive	Yes	No
Raging Anger	Yes	No
On Guard	Yes	No
Impulsive	Yes	No
Hopeless	Yes	No
Suicidal Thoughts	Yes	No

Female Only

Pain with sex	Yes	No
Vaginal Dryness	Yes	No
Hot Flashes/Sweats	Yes	No
Vaginal Discharge	Yes	No
Sore	Yes	No
Itching or Rash	Yes	No
STD's	Yes	No
Hormonal Birth Control	Yes	No
IUD	Yes	No
Severe Cramps	Yes	No
Heavy Periods	Yes	No
Pregancies _____		
Complication during Pregnancy	Yes	No
Type _____		
Births _____		

Male Only

Pain with Sex	Yes	No
Hernia	Yes	No
Penile Discharge	Yes	No
Sores	Yes	No
Masses or Pain	Yes	No
Erectile Dysfunction	Yes	No
STD's	Yes	No

Breats/Pectoralis

Lumps	Yes	No
Pain	Yes	No
Discharge	Yes	No
Self Exams	Yes	No