

Confidential Patient Data

If you need any assistance completing this form, please ask the receptionist.

Legal First Name: _____ Middle Name _____ Last Name: _____

Nickname: _____ Spouse's Name (if applicable) _____

SSN: _____ Female Male Date of Birth: ____/____/____ E-Mail Address: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____

Employment Status: Full-Time Part-Time Retired Un-Employed Child Disabled Homemaker

Occupation Type: _____ Employer's Name: _____

Marital Status: Single Married Divorced Widowed

How did you hear about us? Friend/Family Member – Name: _____ Yellow Pages Mail

Clinic/Primary Care Physician – Name: _____ Other: _____

Primary Care Physician _____ Phone (____) _____

Emergency Contact: _____ Relationship: _____

Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____

Acknowledgement of Receipt of Notice of Privacy Practices

I, the undersigned, acknowledge that I have received, reviewed, understand and agree to the Notice of Privacy Practices of Walsh Chiropractic Center, P.C., which describes the Practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the Practice.

Printed Name: _____ Signature: _____ Date: _____

Informed Consent

I hereby request and consent to the performance of a chiropractic evaluation, chiropractic adjustments, and other chiropractic procedures, including various modes of physical therapy and, if necessary, diagnostic x-rays, on me by Dr. Walsh and/or anyone working in this clinic authorized by Dr. Walsh.

I further understand and am informed that, as in all health care, in the practice of chiropractic there are some very slight risks to treatment, including, but not limited to, muscle strains and sprains, disc injuries, and cerebrovascular accidents. I do not expect the doctor to be able to anticipate and explain all the risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interest.

Printed Name: _____ Signature: _____ Date: _____

Consent to Treat Minors

I, _____, confirm that I am the parent/legal guardian of the above-mentioned patient give consent for chiropractic treatment and diagnostic studies as ordered by the doctors and performed by the technical staff of WALSH FAMILY CHIROPRACTIC CENTER. _____

Signature of Parent/Legal Guardian

Date

Furthermore, I give consent to WALSH FAMILY CHIROPRACTIC CENTER to provide treatment to the above-mentioned minor during scheduled appointments with/without my presence in the facility. ____ (Please Initial)

Financial Policy

Patient First Name: _____ Last Name: _____ SSN _____

Person Responsible for Bill

self (if "self," you do not have to complete the remainder of the information in this shaded box)

another individual

_____ Date of Birth: ____ / ____ / ____
Last Name First Name Middle Name

Mailing Address: _____ City: _____ State: _____ Zip: _____

Relationship to Patient: _____ Home Phone: (____) _____ SSN _____

Is this person a patient here? _____ Employed By: _____ Work Phone: (____) _____

Business Mailing Address: _____ City: _____ State: _____ Zip _____

Payment for Services will be made primarily by:

Cash Check Credit Card Health Insurance Automobile Insurance Worker's Compensation

1. All patients are on a cash basis until their respective insurance coverage and deductible may be verified by our staff.
2. You will have 30 days upon receipt of a Statement of Account to pay in full without penalty. After 30 days you will begin to accrue interest at 14.4% APR.
3. After 90 days, delinquent accounts will be forwarded to a collection agency. At this time all costs associated with collections will become the patient's responsibility. In addition, if you, the patient, choose to acquire an attorney, you, the patient, will be responsible for all attorney fees.
4. This office may make payment plans/arrangements on an individual basis. Any such plan or arrangement will be discussed after your report of findings.
 - a. If you enter into a payment agreement and discontinue care before the plan is completed, you will only be responsible for those services that have been provided to date. If the remaining balance is greater than that amount paid to date (due to the nature of the payment plan) the remaining account balance will be due. Should there be a credit, the credit will be refunded to you. If insurance is involved, refunds will be made after all insurance claims have been settled.
5. If you have questions concerning this or any other matter, please speak with the receptionist prior to seeing the doctor.

It is understood this is a highly specialized, unique and effective method of care. Knowing that 70% of the doctor's knowledge, expertise, time and technical equipment will be utilized in the first three weeks of patient's care; 20% in the second phase, and 10% in the final phase of care.

I have read and understand the Financial Policy.

Patient's Signature

Date

Current Health History

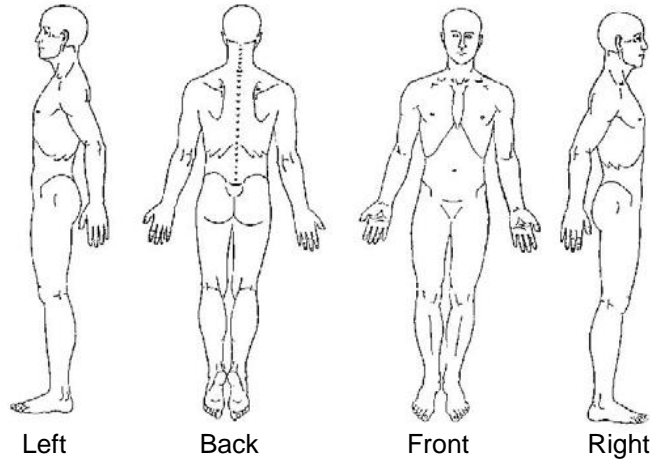
Reason for today's visit: Emergency New Injury Old Injury Chronic Pain Wellness Visit

Please indicate the current complaints you are experiencing by marking the areas on the image below and providing details using the sections that follow.

Are these complaints a result from a Work, Auto, or Other Accident? No Yes
 If yes, explain. _____

Have you seen any other doctor(s) for your present complaint(s)? No Yes
 If yes, who? _____
 What form of treatment did you receive? _____

Are you currently taking any medications for your complaints? No Yes
 If yes, what? _____



1) Area of Complaint:		
When did it begin?		
How did it begin?		
Pain Ratings		<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 (Excruciating)
Frequency		<input type="checkbox"/> Infrequent < 25% <input type="checkbox"/> Occasional 25% to 50% <input type="checkbox"/> Frequent 50% to 75% <input type="checkbox"/> Constant > 75%
Pain Type		<input type="checkbox"/> No Pain <input type="checkbox"/> Pain <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling <input type="checkbox"/> Muscle Spasms <input type="checkbox"/> Burning
Severity		<input type="checkbox"/> Mild <input type="checkbox"/> Mild to Moderate <input type="checkbox"/> Moderate <input type="checkbox"/> Moderate to Severe <input type="checkbox"/> Severe
What makes it better?		<input type="checkbox"/> Medication <input type="checkbox"/> Stretching <input type="checkbox"/> Bending <input type="checkbox"/> Reaching <input type="checkbox"/> Twisting / turning <input type="checkbox"/> Pushing / pulling <input type="checkbox"/> Lifting <input type="checkbox"/> Lying down <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Walking <input type="checkbox"/> Sneezing <input type="checkbox"/> Coughing <input type="checkbox"/> Other:
What makes it worse?		<input type="checkbox"/> General Movements <input type="checkbox"/> Bending <input type="checkbox"/> Reaching <input type="checkbox"/> Twisting / turning <input type="checkbox"/> Pushing / pulling <input type="checkbox"/> Lifting <input type="checkbox"/> Lying down <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Walking <input type="checkbox"/> Sneezing <input type="checkbox"/> Coughing <input type="checkbox"/> Other:
Does the pain radiate to any other locations?	Upper Body	<input type="checkbox"/> Head <input type="checkbox"/> Forehead <input type="checkbox"/> Back of head <input type="checkbox"/> Right side of head <input type="checkbox"/> Left side of head <input type="checkbox"/> Neck <input type="checkbox"/> Right Ear <input type="checkbox"/> Left Ear <input type="checkbox"/> Right Eye <input type="checkbox"/> Left Eye <input type="checkbox"/> Face <input type="checkbox"/> Right Jaw <input type="checkbox"/> Left Jaw <input type="checkbox"/> Right Upper back <input type="checkbox"/> Left Upper back <input type="checkbox"/> Right Shoulder <input type="checkbox"/> Left Shoulder <input type="checkbox"/> Right Chest <input type="checkbox"/> Left Chest <input type="checkbox"/> Right Ribs <input type="checkbox"/> Left Ribs
	Mid Body	<input type="checkbox"/> Right Mid back <input type="checkbox"/> Left Mid back <input type="checkbox"/> Right Lower back <input type="checkbox"/> Left Lower back <input type="checkbox"/> Right Hip <input type="checkbox"/> Left Hip <input type="checkbox"/> Right Buttock <input type="checkbox"/> Left Buttock <input type="checkbox"/> Groin <input type="checkbox"/> Right Arm <input type="checkbox"/> Left Arm <input type="checkbox"/> Right forearm <input type="checkbox"/> Left forearm <input type="checkbox"/> Right hand <input type="checkbox"/> Left hand <input type="checkbox"/> Right fingers <input type="checkbox"/> Left fingers
	Lower Body	<input type="checkbox"/> Right Thigh <input type="checkbox"/> Left Thigh <input type="checkbox"/> Right Knee <input type="checkbox"/> Left Knee <input type="checkbox"/> Right Calf <input type="checkbox"/> Left Calf <input type="checkbox"/> Right Toes <input type="checkbox"/> Left Toes <input type="checkbox"/> Right Foot <input type="checkbox"/> Left Foot <input type="checkbox"/> Right Toes <input type="checkbox"/> Left Toes
Described as		<input type="checkbox"/> Aching <input type="checkbox"/> Dull <input type="checkbox"/> Sharp <input type="checkbox"/> Stabbing <input type="checkbox"/> Throbbing <input type="checkbox"/> Other:
At it's worst		<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Night After Activities: <input type="checkbox"/> Light <input type="checkbox"/> Moderate
Associated with		<input type="checkbox"/> Dizziness <input type="checkbox"/> Nausea <input type="checkbox"/> Visual Problems <input type="checkbox"/> Ringing/Buzzing ears <input type="checkbox"/> Bright Light Sensitivity <input type="checkbox"/> Loss of balance <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling <input type="checkbox"/> Tightness <input type="checkbox"/> Stiffness
Other Comments or Remarks		

Patient's Signature

Date

Current Health History, continued

2) Area of Complaint:	
When did it begin?	
How did it begin?	
Pain Ratings	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 (Excruciating)
Frequency	<input type="checkbox"/> Infrequent < 25% <input type="checkbox"/> Occasional 25% to 50% <input type="checkbox"/> Frequent 50% to 75% <input type="checkbox"/> Constant > 75%
Pain Type	<input type="checkbox"/> No Pain <input type="checkbox"/> Pain <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling <input type="checkbox"/> Muscle Spasms <input type="checkbox"/> Burning
Severity	<input type="checkbox"/> Mild <input type="checkbox"/> Mild to Moderate <input type="checkbox"/> Moderate <input type="checkbox"/> Moderate to Severe <input type="checkbox"/> Severe
What makes it better?	<input type="checkbox"/> Medication <input type="checkbox"/> Stretching <input type="checkbox"/> Bending <input type="checkbox"/> Reaching <input type="checkbox"/> Twisting / turning <input type="checkbox"/> Pushing / pulling <input type="checkbox"/> Lifting <input type="checkbox"/> Lying down <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Walking <input type="checkbox"/> Sneezing <input type="checkbox"/> Coughing <input type="checkbox"/> Other:
What makes it worse?	<input type="checkbox"/> General Movements <input type="checkbox"/> Bending <input type="checkbox"/> Reaching <input type="checkbox"/> Twisting / turning <input type="checkbox"/> Pushing / pulling <input type="checkbox"/> Lifting <input type="checkbox"/> Lying down <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Walking <input type="checkbox"/> Sneezing <input type="checkbox"/> Coughing <input type="checkbox"/> Other:
Does the pain radiate to any other locations?	Upper Body <input type="checkbox"/> Head <input type="checkbox"/> Forehead <input type="checkbox"/> Back of head <input type="checkbox"/> Right side of head <input type="checkbox"/> Left side of head <input type="checkbox"/> Neck <input type="checkbox"/> Right Ear <input type="checkbox"/> Left Ear <input type="checkbox"/> Right Eye <input type="checkbox"/> Left Eye <input type="checkbox"/> Face <input type="checkbox"/> Right Jaw <input type="checkbox"/> Left Jaw <input type="checkbox"/> Right Upper back <input type="checkbox"/> Left Upper back <input type="checkbox"/> Right Shoulder <input type="checkbox"/> Left Shoulder <input type="checkbox"/> Right Chest <input type="checkbox"/> Left Chest <input type="checkbox"/> Right Ribs <input type="checkbox"/> Left Ribs
	Mid Body <input type="checkbox"/> Right Mid back <input type="checkbox"/> Left Mid back <input type="checkbox"/> Right Lower back <input type="checkbox"/> Left Lower back <input type="checkbox"/> Right Hip <input type="checkbox"/> Left Hip <input type="checkbox"/> Right Buttock <input type="checkbox"/> Left Buttock <input type="checkbox"/> Groin <input type="checkbox"/> Right Arm <input type="checkbox"/> Left Arm <input type="checkbox"/> Right forearm <input type="checkbox"/> Left forearm <input type="checkbox"/> Right hand <input type="checkbox"/> Left hand <input type="checkbox"/> Right fingers <input type="checkbox"/> Left fingers
	Lower Body <input type="checkbox"/> Right Thigh <input type="checkbox"/> Left Thigh <input type="checkbox"/> Right Knee <input type="checkbox"/> Left Knee <input type="checkbox"/> Right Calf <input type="checkbox"/> Left Calf <input type="checkbox"/> Right Toes <input type="checkbox"/> Left Toes <input type="checkbox"/> Right Foot <input type="checkbox"/> Left Foot <input type="checkbox"/> Right Toes <input type="checkbox"/> Left Toes
Described as	<input type="checkbox"/> Aching <input type="checkbox"/> Dull <input type="checkbox"/> Sharp <input type="checkbox"/> Stabbing <input type="checkbox"/> Throbbing <input type="checkbox"/> Other:
At it's worst	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Night After Activities: <input type="checkbox"/> Light <input type="checkbox"/> Moderate
Associated with	<input type="checkbox"/> Dizziness <input type="checkbox"/> Nausea <input type="checkbox"/> Visual Problems <input type="checkbox"/> Ringing/Buzzing ears <input type="checkbox"/> Bright Light Sensitivity <input type="checkbox"/> Loss of balance <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling <input type="checkbox"/> Tightness <input type="checkbox"/> Stiffness
Other Comments or Remarks	

Patient's Signature

Date

For Additional Complaints, Please Ask Receptionist for Additional Pages

Current Health History, continued

<u>Date of Last:</u>	<u>< 6 months</u>	<u>6-12 months</u>	<u>>12 months</u>	<u>Never</u>
Spinal examination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical examination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood test	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chest x-ray	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spinal x-ray	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dental x-ray	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urine test	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Habits:</u>	<u>Heavy</u>	<u>Moderate</u>	<u>Light</u>	<u>None</u>
Alcoholic beverages	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coffee/tea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco products	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recreational drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SURGICAL HISTORY:

1. _____ Date: _____
 2. _____ Date: _____
 3. _____ Date: _____

ACCIDENT HISTORY:

1. _____ Date: _____ Job Auto Other: _____
 2. _____ Date: _____ Job Auto Other: _____
 3. _____ Date: _____ Job Auto Other: _____

OCCUPATION:

1a. Job Title: _____ Years in Job: _____
 2. My typical work day would be described as follows: _____

FAMILY MEDICAL HISTORY M = Mother F = Father S = Sibling C=Children

(Please indicate which conditions have been experienced by the above by marking appropriate boxes).

M F S C	M F S C	M F S C
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> AIDS/HIV/ARC	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Chronic low back pain	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Multiple sclerosis
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Anemia	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Chronic ear infections	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Muscular dystrophy
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Arthritic disorders	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Diabetes	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Neuralgia
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Asthma	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Epilepsy	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Polio
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bladder troubles	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Heart disease	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Reflux
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bowel problems	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hepatitis	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Reproductive disease
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Cancer	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> High blood pressure	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sinusitis
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Chronic headaches	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Kidney disorder	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Scoliosis
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Chronic neck pain	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Migraine headache	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Tuberculosis

c

Patient's Name: _____ **Date:** _____

Confidential Health Report

This form is for IN-HOUSE USE ONLY. Please check the appropriate box for any of the following symptoms which you now have or have had within the last 6 months. If you are currently taking medication for the symptom, please check the box marked with the letter 'M'. We want all the facts about your health before we accept your case.

M – MEDICATION
L6 – LAST 6 MONTHS
C – CURRENTLY

M L6 C GENERAL

- Allergy
- Chills
- Convulsions
- Dizziness
- Fainting
- Fatigue
- Fever
- Headache
- Loss of sleep
- Loss of weight
- Nervousness/depression
- Neuralgia
- Numbness
- Sweats
- Tremors

MUSCLE & JOINT

- Arthritis
- Bursitis
- Foot trouble
- Hernia
- Low back pain
- Lumbago
- Neck pain or stiffness
- Pain between shoulders
- Pain or numbness in:
 - Shoulders
 - Arms
 - Elbows
 - Hands
 - Hips
 - Legs
 - Knees
 - Feet
- Painful tail bone
- Poor posture
- Sciatica
- Spinal Curvature
- Swollen joints

M L6 C GASTRO-INTESTINAL

- Belching or gas
- Colitis
- Colon trouble
- Constipation
- Diarrhea
- Difficult digestion
- Distension of abdomen
- Excessive hunger
- Gall bladder trouble
- Hemorrhoids
- Intestinal worms
- Jaundice
- Liver trouble
- Nausea
- Pain over stomach
- Poor appetite
- Vomiting
- Vomiting of blood

EYES, EARS, NOSE & THROAT

- Asthma
- Colds
- Crossed eyes
- Deafness
- Dental decay
- Earache
- Ear discharge
- Ear noises
- Enlarged glands
- Enlarged thyroid
- Eye pain
- Failing vision
- Far sightedness
- Gum trouble
- Hay fever
- Hoarseness
- Nasal obstruction
- Near sightedness
- Nosebleeds
- Sinus infection
- Sore throat
- Tonsillitis

M L6 C CARDIO-VASCULAR

- Hardening of arteries
- High blood pressure
- Low blood pressure
- Pain over heart
- Poor circulation
- Rapid heart beat
- Slow heart beat
- Swelling of ankles

RESPIRATORY

- Chest pain
- Chronic cough
- Difficult breathing
- Spitting up blood
- Spitting up phlegm
- Wheezing

SKIN

- Boils
- Bruise easily
- Dryness
- Hives or allergy
- Itching
- Skin eruptions (rash)
- Varicose veins

GENITO-URINARY

- Bed-wetting
- Blood in urine
- Frequent urination
- Inability to control kidneys
- Kidney infection or stones
- Painful urination
- Prostate trouble
- Pus in urine

FOR WOMEN ONLY

- Congested breasts
- Cramps or backache
- Excessive menstrual flow
- Hot flashes
- Irregular cycle
- Menopausal symptoms
- Painful menstruation
- Vaginal discharge

Other: _____ Other: _____ Other: _____

CHECK THE FOLLOWING CONDITIONS YOU HAVE HAD:

- | | | | | |
|---|---|--|---|---|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Cold sores | <input type="checkbox"/> Goiter | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Scarlet fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Gout | <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Mumps | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Eczema | <input type="checkbox"/> Influenza | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Typhoid fever |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Lumbago | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Chorea | <input type="checkbox"/> Fever blisters | <input type="checkbox"/> Measles | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Whooping cough |

Patient's Name: _____ **Date:** _____

