

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: (____) _____

Preferred method of communication for patient reminders: Email Phone Mail

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

Occupation Type: _____ Employer's Name: _____

Marital Status: Single Married Divorced Widowed Separated

*Race: American Indian or Alaska Native Asian Black or African American White (Caucasian)
 Native Hawaiian or Pacific Islander Other I Decline to Answer

Preferred Language: _____

*Ethnicity: Hispanic or Latino Not Hispanic or Latino I Decline to Answer

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: _____

* CMS requires providers to report both race and ethnicity.

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. A \$10.00 processing fee will be charged for all returned checks.
5. 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.
6. 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 Injury, Auto Accident, or Other Accident? No Yes

If yes, explain. _____

Have you experienced these complaints before? No Yes

Has your condition? ___ Improved ___ Worsened ___ Stayed the same since it began

Have you seen any other doctor(s) for your present complaints(s)?

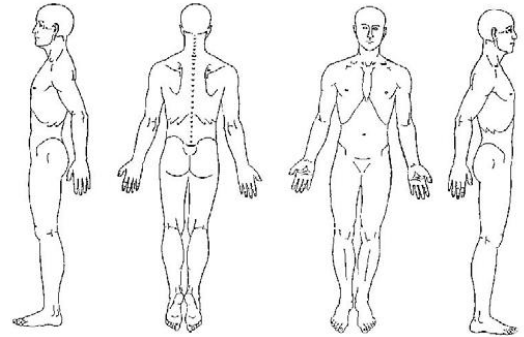
No Yes If yes, who? _____
When? _____

Did you receive MRIs, x-rays, or diagnostic testing? No Yes

What form of treatment did you receive? _____

Are you currently taking any medications for your complaints?

No Yes If yes, what? _____



Left Back Front Right

1) Area of Complaint	List Primary Complaint – One Complaint Per Page	
When did it begin?		
How did it begin?		
Complaint Rating	<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%	
Complaint 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 <input type="checkbox"/> Aching <input type="checkbox"/> Dull <input type="checkbox"/> Sharp <input type="checkbox"/> Stabbing <input type="checkbox"/> Throbbing <input type="checkbox"/> Other:	
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 complaint 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
At its 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		List Secondary Complaint – One Complaint Per Page
When did it begin?		
How did it begin?		
Complaint Rating		<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%
Complaint 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 <input type="checkbox"/> Aching <input type="checkbox"/> Dull <input type="checkbox"/> Sharp <input type="checkbox"/> Stabbing <input type="checkbox"/> Throbbing <input type="checkbox"/> Other:
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 complaint 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
At its 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 Initials _____

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"/>
Caffeine	<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"/>

	<u>Current Every Day</u>	<u>Current Some Day</u>	<u>Former</u>	<u>Never</u>
<u>Smoking Habit:</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SURGICAL HISTORY:

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

ACCIDENT HISTORY:

1. _____	Date: _____	<input type="checkbox"/> Job	<input type="checkbox"/> Auto	<input type="checkbox"/> Other: _____
2. _____	Date: _____	<input type="checkbox"/> Job	<input type="checkbox"/> Auto	<input type="checkbox"/> Other: _____
3. _____	Date: _____	<input type="checkbox"/> Job	<input type="checkbox"/> Auto	<input type="checkbox"/> Other: _____

OCCUPATION:

Job Title: _____ Years in Job: _____

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

Patient's Initials: _____ **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
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergy
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chills
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fainting
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fatigue
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fever
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Headache
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loss of sleep or Apnea
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loss of weight
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nervousness/depression
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neuralgia
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Numbness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sweats
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tremors
			MUSCLE & JOINT
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bursitis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Foot trouble
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hernia
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Low back pain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lumbago
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neck pain or stiffness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain between shoulders
			Pain or numbness in:
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shoulders
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arms
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Elbows
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hands
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hips
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Legs
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Knees
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Feet
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Painful tail bone
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Poor posture
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sciatica
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Spinal Curvature
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Swollen joints
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____

M	L6	C	GASTRO-INTESTINAL
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Belching or gas
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Colitis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Colon trouble
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Constipation
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficult digestion
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Distension of abdomen
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excessive hunger
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gall bladder trouble
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Intestinal worms
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Liver trouble
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nausea
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain over stomach
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Poor appetite
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting of blood
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	IBS
			EYES, EARS, NOSE & THROAT
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Colds
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Crossed eyes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Deafness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dental decay
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Earache
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ear discharge
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ear noises
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Enlarged glands
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Enlarged thyroid
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eye pain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Failing vision
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Far sightedness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gum trouble
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hay fever
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hoarseness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nasal obstruction
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Near sightedness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nosebleeds
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus infection
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sore throat
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tonsillitis

M	L6	C	CARDIO-VASCULAR
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hardening of arteries
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Low blood pressure
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain over heart
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Poor circulation
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rapid heart beat
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Slow heart beat
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Swelling of ankles
			RESPIRATORY
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic cough
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficult breathing
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Spitting up blood
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Spitting up phlegm
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Wheezing
			SKIN
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Boils
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bruise easily
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dryness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hives or allergy
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Itching
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin eruptions (rash)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Varicose veins
			GENITO-URINARY
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bed-wetting
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood in urine
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent urination
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Inability to control kidneys
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney infection or stones
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Painful urination
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Prostate trouble
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pus in urine
			FOR WOMEN ONLY
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Congested breasts
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cramps or backache
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excessive menstrual flow
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hot flashes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Irregular cycle
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Menopausal symptoms
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Painful menstruation
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vaginal discharge
			<input type="checkbox"/> Yes <input type="checkbox"/> No Are you pregnant?
			If yes, due date: _____
			# of previous pregnancies: _____

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 Initials: _____ **Date:** _____

Medications

Name of Medications (to include prescription drugs & OTC drugs)	Condition	Dosage and Frequency (i.e. 5mg once a day, etc.)

Supplements

Medication Allergies

Medication Name	Reaction	Onset Date	Additional Comments

Patient's Signature

Date