CONFIDENTIAL HEALTH REPORT

Name_____**Social Security No**_____
Address_____**Driver's License No**_____
City_____**State**_____**Zip**_____**Married**_____**S**_____**D**_____**W**_____
Home Phone_____**Cell Phone**_____**Work Phone**_____
Age_____**Birthdate**_____**Sex**_____**Email**_____
No. of Children_____ **Height**_____**Weight**_____ **Referred By**_____
Occupation_____**Employer**_____ **Insurance Co**_____
Person financially responsible for account_____
Describe Major Complaints and Symptoms_____
_____
Date you First Noticed Symptoms_____**How was the Condition Caused**_____
_____
Has this Condition Happened Before_____**When**_____
Have you been treated by another Doctor for this Condition_____
Name of Doctor_____**Diagnosis**_____
Length of Time under Care_____**Results**_____
Have you ever been in an accident_____**Auto, Work, Home, Leisure, Other**_____
Describe Including Dates_____
Describe Fractures Past or Present_____
Describe any type of Surgery_____
Describe the Medication you are taking for any condition_____
_____
In the past have you taken Medication on a Regular Basis_____
Date of Last Medical Physical_____**Chiropractic Exam**_____

CHECK THE FOLLOWING CONDITIONS YOU HAVE HAD

__**Alcoholism**	__**Diabetes**	__**Measles**	__**Stroke**
__**Anemia**	__**Diphtheria**	__**Multiple Sclerosis**	__**Tonsillitis**
__**Appendicitis**	__**Eczema**	__**Mumps**	__**Tuberculosis**
__**Arteriosclerosis**	__**Emphysema**	__**Pleurisy**	__**Typhoid Fever**
__**Asthma**	__**Epilepsy**	__**Pneumonia**	__**Veneral Disease**
__**Cancer**	__**Goiter**	__**Polio**	__**Whooping Cough**
__**Chicken Pox**	__**Heart Disease**	__**Rheumatic Fever**	__ _____
__**Cold Sores**	__**Hypoglycemia**	__**Scarlet Fever**	__ _____

Name of Nearest Relative (not living with you)_____
Address_____
Telephone_____**Relationship**_____

Your signature below will verify that all the information you have given us is accurate and that you have answered the health report questions entirely.

Sign Your Name_____**Date**_____

PLEASE CHECK ANY OF THE FOLLOWING SYMPTOMS WHICH YOU NOW HAVE OR HAVE HAD IN THE PAST

N = NOW
P = PAST

N	P	
		GENERAL
__	__	Allergy
__	__	Chills
__	__	Convulsions
__	__	Depression
__	__	Dizziness
__	__	Fainting
__	__	Headache
__	__	Loss of Sleep
__	__	Loss of Weight
__	__	Nervousness
__	__	Tremors
		MUSCLE & JOINT
__	__	Arthritis
__	__	Bursitis
__	__	Hernia
__	__	Low Back Pain
__	__	Neck Pain or Stiffness
__	__	Pain Between Shoulders
		PAIN OR NUMBNESS IN:
__	__	Shoulders
__	__	Arms
__	__	Elbows
__	__	Hands
__	__	Hips
__	__	Legs
__	__	Knees
__	__	Feet
__	__	Painful Tailbone
__	__	Sciatica
__	__	Swollen Joints

N	P	
		GASTRO-INTESTINAL
__	__	Belching or Gas
__	__	Colon Trouble
__	__	Constipation
__	__	Diarrhea
__	__	Difficult Digestion
__	__	Gall Bladder Trouble
__	__	Hemorrhoids
__	__	Jaundice
__	__	Liver Trouble
__	__	Nausea
__	__	Pain over Stomach
__	__	Ulcers
		E.E.N.T.
__	__	Colds
__	__	Crossed Eyes
__	__	Deafness
__	__	Earache
__	__	Ear Noises
__	__	Enlarged Glands
__	__	Eye Flashes
__	__	Eye Pain
__	__	Hay fever
__	__	Hoarseness
__	__	Nasal Obstruction
__	__	Nosebleeds
__	__	Sinus Infection
__	__	Sore Throat
		CARDIOVASCULAR
__	__	Hardening Arteries
__	__	High Blood Pressure
__	__	Low Blood Pressure
__	__	Pain Over Heart
__	__	Cold Hands or Feet
__	__	Rapid Heart Beat
__	__	Slow Beating Heart
__	__	Swelling Ankles
__	__	Varicose Veins

N	P	
		RESPIRATORY
__	__	Chest Pain
__	__	Chronic Cough
__	__	Difficult Breathing
__	__	Spitting up Blood
__	__	Spitting up Phlegm
__	__	Wheezing
		SKIN
__	__	Bruise Easily
__	__	Dryness
__	__	Hives or Allergy
__	__	Itching
__	__	Skin Lesions (Rash)
		GENITO-URINARY
__	__	Bed Wetting
__	__	Blood in Urine
__	__	Frequent Urination
__	__	Can't Control Urine
__	__	Painful Urination
__	__	Prostate Trouble
__	__	Puss in Urine
		FOR WOMEN ONLY
__	__	Cramps or Backache
__	__	Excessive Flow
__	__	Hot Flashes
__	__	Irregular Cycle
__	__	Lumps in Breast
__	__	Menopausal Symptoms
__	__	Painful Menses
__	__	Vaginal Discharge
__	__	Miscarriage

Are You Pregnant?
YES_____NO_____