My current symptoms are increased or aggravated with the following activities:

□ Walking □ Bending
□ Sleeping □ Lying
□ Standing □ Sitting
□ Lifting
□ Other _____
□ Other _____

For each of the conditions listed below, place a check in the Past column if you have had the condition in the past.
If you presently have a condition listed below, place a check in the Present column.

Past	Present	
□	□	Headaches
□	□	Neck Pain
□	□	Upper Back Pain
□	□	Mid Back Pain
□	□	Low Back Pain
□	□	Shoulder Pain
□	□	Elbow/Upper Arm Pain
□	□	Wrist Pain
□	□	Hand Pain
□	□	Hip/Upper Leg Pain
□	□	Knee/Lower Leg Pain
□	□	Ankle/Foot Pain
□	□	Jaw Pain
□	□	Joint Swelling/Stiffness
□	□	Arthritis
□	□	Rheumatoid Arthritis
□	□	General Fatigue
□	□	Muscular Incoordination
□	□	Visual Disturbances
□	□	Dizziness

Past	Present	
□	□	High Blood Pressure
□	□	Heart Attack
□	□	Chest Pains
□	□	Stroke
□	□	Angina
□	□	Kidney Stones
□	□	Bladder Infection
□	□	Painful Urination
□	□	Loss of Bladder Control
□	□	Prostate Problems
□	□	Abnormal Weight Gain/Loss
□	□	Loss of Appetite
□	□	Abdominal Pain
□	□	Ulcer
□	□	Hepatitis
□	□	Liver/Gall Bladder Disorder
□	□	Cancer
□	□	Tumor
□	□	Asthma
□	□	Chronic Sinusitis

Past	Present	
□	□	Diabetes
□	□	Excessive Thirst
□	□	Frequent Urination
□	□	Smoking/Use of Tabacco Products
□	□	Drug/Alcohol Dependence
□	□	Allergies
□	□	Depression
□	□	Systemic Lupus
□	□	Epilepsy
□	□	Dermatitis/Eczema/Rash
□	□	HIV/AIDS

Females Only

□	□	Birth Control Pills
□	□	Hormonal Replacement
□	□	Pregnancy
□	□	

Other Health Problems/Issues

□	□	_____
□	□	_____
□	□	_____

Indicate if an immediate family member has had any of the following:

□ Rheumatoid Arthritis □ Heart Problems □ Diabetes □ Cancer □ Lupus □ _____

Have you ever been under Chiropractic Care? **Y / N** If so, By whom? _____

Have you had any SPINAL X-Rays / MRI's / CT's taken in the last year? **Y / N** If so, Where? _____

What operations have you had? _____ When? _____

Serious Illness: _____ When? _____

Infectious Diseases: _____ When? _____

Do you have a pace maker? **Y / N** Have you ever had any Hip or Knee Replacements **Y / N**

What medications or drugs are you taking? (check those that apply): Pain Killers ____ Insulin _____ Cholesterol Meds _____

Blood Pressure Meds ___ Muscle Relaxers ___ Birth Control ___ Other: _____

What is your goal in our office? _____

I certify that the above information is accurate to the best of my knowledge.

Patient/Guardian Signature _____ Date: _____