

INITIAL HEALTH STATUS

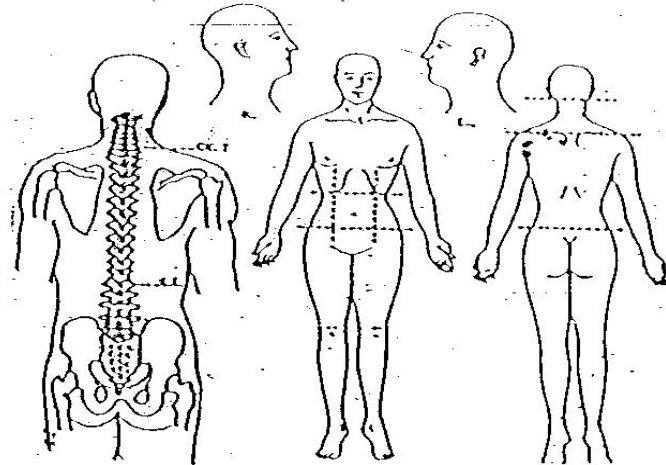
Patient Name: _____

Date: _____

In the diagrams below, mark the areas of the body, using the symbols, where you have experienced any of the following symptoms **this past week**:

Symbols

ACHING	XXXX
BURNING	AAAA
STABBING	////
PINS & NEEDLES	0000
NUMBNESS	-----



Please check all of the following that apply to you: None Apply

- | | |
|---|---|
| <input type="checkbox"/> Recent Fever
<input type="checkbox"/> Diabetes
<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Stroke (date) _____
<input type="checkbox"/> Corticosteroid Use (cortisone, prednisone, etc.)
<input type="checkbox"/> Taking Birth Control Pills
<input type="checkbox"/> Dizziness/Fainting
<input type="checkbox"/> Numbness in Groin/Buttocks
<input type="checkbox"/> Cancer/Tumor (explain) _____
<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Epilepsy/Seizures
<input type="checkbox"/> Other Health Problems (explain) _____
_____ | <input type="checkbox"/> Prostate Problems
<input type="checkbox"/> Menstrual Problems
<input type="checkbox"/> Urinary Problems
<input type="checkbox"/> Currently Pregnant, #weeks _____, #births _____
<input type="checkbox"/> Abnormal Weight <input type="checkbox"/> Gain <input type="checkbox"/> Loss
<input type="checkbox"/> Marked Morning Pain/Stiffness
<input type="checkbox"/> Pain Unrelieved by Position or Rest
<input type="checkbox"/> Pain at Night
<input type="checkbox"/> Visual Disturbances
<input type="checkbox"/> Surgeries _____

<input type="checkbox"/> Medications _____

<input type="checkbox"/> History of Alcohol Use <input type="checkbox"/> History of Tobacco Use |
|---|---|

Family History: Cancer Diabetes High Blood Pressure Heart Problems/Stroke Rheumatoid Arthritis

I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my chiropractor may need to contact my physician if my condition needs to be co-managed. Therefore, I give authorization to my chiropractor to contact my physician, if necessary.

Patient Signature _____

Date _____