

It is important for the doctor to know of your past history. Please check all that apply to your past medical history.

General Symptoms

- Allergies
- Bronchitis
- Chills
- Convulsions
- Dizziness
- Fainting
- Fatigue
- Fever
- Headache
- Loss of sleep
- Loss/ Gain of weight
- Nervousness
- Neuralgia
- Night Sweats
- Numbness or pain in arms/legs/hands
- Wheezing

Gastro-Intestinal

- Belching or Gas
- Colon trouble
- Constipation
- Diarrhea
- Excessive hunger/thirst
- Gall bladder trouble
- Hemorrhoids (piles)
- Jaundice
- Liver trouble
- Nausea
- Pain over stomach
- Poor Appetite
- Poor Digestion
- Vomiting
- Vomiting blood

Eye/Ear/Nose/Throat

- Asthma
- Crossed eyes
- Deafness
- Earache
- Ear discharge
- Enlarged thyroid
- Frequent colds
- Hay fever
- Hoarseness
- Nasal Obstruction
- Nose bleeds
- Pain in eyes
- Poor vision
- Sinusitis
- Sore throats
- Tonsillitis

Genito-Urinary

- Bed wetting
- Blood in urine
- Frequent urination
- Unable to control urine
- Kidney infection
- Painful urination
- Prostate trouble

Respiratory

- Chest pain
- Chronic cough
- Difficulty breathing
- Spitting blood
- Spitting phlegm

Cardio-Vascular

- High blood pressure
- Low blood pressure
- Pain over heart
- Poor circulation
- Previous heart trouble
- Rapid heart
- Slow heart
- Strokes
- Swelling ankles
- Varicose veins

Skin or Allergies

- Boils
- Bruising easily
- Dryness
- Eczema
- Hives or allergy
- Itching
- Sensitive skin
- Skin eruptions

For Women Only

- Cramps or backaches
- Excessive flow
- Hot flashes
- Irregular cycle
- Miscarriage
- Painful periods
- Pregnant at this time

AUTHORIZATION AND RELEASE:

I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

I understand and agree to allow this chiropractic office to use my Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPPA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

Patient's/Guardian's Signature: _____ **Date:** _____