




THE NERVOUS SYSTEM CONTROLS AND COORDINATES ALL ORGANS AND STRUCTURES OF THE HUMAN BODY.

Please check the boxes for each symptom you have experienced — including past and present.

REGIONS	FUNCTIONS	SYMPTOMS				
 Cervical	General Health	<input type="checkbox"/> Colic / Cramping	<input type="checkbox"/> Vertigo / Dizziness	<input type="checkbox"/> Low Energy		
	Immune System	<input type="checkbox"/> Difficulty Sleeping	<input type="checkbox"/> Epilepsy / Seizures	<input type="checkbox"/> ADD / ADHD		
	Eyes, Ears, Nose, Mouth	<input type="checkbox"/> Weight Change	<input type="checkbox"/> Memory Issue	<input type="checkbox"/> Anxiety / Depression		
		<input type="checkbox"/> Allergies	<input type="checkbox"/> Asthma	<input type="checkbox"/> Flu or Cold		
		<input type="checkbox"/> Eye Problem	<input type="checkbox"/> Ear Infection	<input type="checkbox"/> Sinus Congestion		
		<input type="checkbox"/> Ear Noises	<input type="checkbox"/> Sore Throat / Strep	<input type="checkbox"/> Swollen Tonsils		
		<input type="checkbox"/> Neck Pain	<input type="checkbox"/> CTS	<input type="checkbox"/> Hand Numbness		
		<input type="checkbox"/> Headache / Migraine	<input type="checkbox"/> Balance Problem	<input type="checkbox"/> TMJ / Jaw Pain		
	Thoracic	Cardiovascular	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Irregular Heartbeat	
		Respiratory	<input type="checkbox"/> Poor Circulation	<input type="checkbox"/> Ankle Swelling	<input type="checkbox"/> Chronic Cough	
Upper Digestion		<input type="checkbox"/> Asthma	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Poor Appetite		
Urinary		<input type="checkbox"/> Nausea	<input type="checkbox"/> Acid Reflux / G.E.R.D.	<input type="checkbox"/> Burping / Gas		
		<input type="checkbox"/> Gas Pain / Bloating	<input type="checkbox"/> Gall Stones	<input type="checkbox"/> Skin Condition / Rash		
		<input type="checkbox"/> Dialysis	<input type="checkbox"/> Bed Wetting	<input type="checkbox"/> Bladder / Urination Issues		
		<input type="checkbox"/> Difficulty Urinating	<input type="checkbox"/> Painful Urination	<input type="checkbox"/> Upper Back Pain		
Lumbar		Lower Digestion	<input type="checkbox"/> Constipation	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Crohn's Disease	
		Sacral	Hormone Control	<input type="checkbox"/> Colitis	<input type="checkbox"/> IBS	<input type="checkbox"/> Menstrual Issues
				<input type="checkbox"/> Endometriosis	<input type="checkbox"/> Irregular Cycle	<input type="checkbox"/> Hot Flashes
			<input type="checkbox"/> Infertility	<input type="checkbox"/> Prostate Issues	<input type="checkbox"/> Lower Back Pain	
			<input type="checkbox"/> Sciatica / Leg Pain	<input type="checkbox"/> Neuropathy	<input type="checkbox"/> Foot Numbness	

Family History

Check any conditions that you or your immediate family has or has had in the past.

SELF	FAMILY	SELF	FAMILY	SELF	FAMILY	SELF	FAMILY	SELF	FAMILY
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gout	Rheumatoid Arthritis	Other Arthritis	Psoriasis	Degenerative Discs					
Shingles	Bell's Palsy	Ulcers	Kidney Stones	Appendicitis					
Parkinson's	Multiple Sclerosis	Cancer	Diabetes	Raynaud's Syndrome					
Stroke / TIA	Heart Attack	Back / Neck Surgery	Pacemaker	Defibrillator					

Surgeries and dates: _____

Broken bone history and dates: _____

Motor vehicle collisions and dates: _____

Do you wear orthotics, heel lifts, or arch supports? _____ For how long? _____

Previous chiropractor name: _____ Last adjustment: _____

What was the primary reason for your previous chiropractic care? Relief Care — Temporary relief of pain or discomfort symptoms.

Corrective Care — Correcting, relieving & stabilizing spinal misalignments.

Wellness Care — Seeking optimal health & function by reducing nerve interference.

Signature: _____ Date: _____