ABSHIRE CHIROPRACTIC

7992 Maurice Avenue
Maurice, LA 70555

Date_____

Patient Name_____ Birthdate_____

CONDITIONS (Check conditions you have or have had in the past.)

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding disorders
- ☐ Breast lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical dependency
- ☑ Chicken pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fractures
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart attack
- ☐ Heart disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High cholesterol
- ☐ HIV positive
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Measles
- ☐ Migraine headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple sclerosis
- ☐ Mumps
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate problem
- ☐ Prosthesis
- ☐ Psychiatric care
- ☐ Rheumatoid arthritis

MEDICATIONS (List all medications you are currently taking)

_____

_____

_____

Allergies_____

Pharmacy Name_____

NECK, BACK, EXTREMITIES (Check symptoms you currently have or have had in the past year.)

NECK

- ☐ Pain in neck
- ☐ Neck stiffness
- ☐ Neck weakness
- ☐ Pinched nerve in neck
- ☐ Neck feels out of place
- ☐ Muscle spasms in neck
- ☐ Grinding/popping sounds in neck

SHOULDERS	Right	Left
☐ Pain in shoulder joint	☐	☐
☐ Pain across shoulders		
☐ Can't raise arm	☐	☐
☐ Above shoulder level		
☐ Over head		
☐ Tension in shoulders		
☐ Pinched nerve in shoulder	☐	☐

MID-BACK

- ☐ Mid-back pain
- ☐ Mid-back stiffness
- ☐ Pain between shoulder blades
- ☐ Pain from front to back
- ☐ Muscle spasms in mid-back

LOW BACK

- ☐ Low back pain
- ☐ Low back stiffness
- ☐ Low back feels out of place
- ☐ Muscle spasms in low back
- ☐ Low back weakness
- ☐ Pinched nerve in low back

ARMS & HANDS	Right	Left
☐ Pain in upper arm	☐	☐
☐ Pain in elbow	☐	☐
☐ Pain in forearm	☐	☐
☐ Pain in hand	☐	☐
☐ Pain in fingers	☐	☐
☐ Pins & needles in arm	☐	☐
☐ Pins & needles in fingers	☐	☐
☐ Numbness in arm	☐	☐
☐ Numbness in fingers	☐	☐
☐ Weakness of arm	☐	☐
☐ Weakness of hand	☐	☐
☐ Hands cold	☐	☐

HIPS, LEGS & FEET

- ☐ Pain in buttocks
- ☐ Pain in hip joint
- ☐ Pain down leg
- ☐ Pain in ankle
- ☐ Pain in foot
- ☐ Weakness of leg
- ☐ Weakness of knee
- ☐ Leg Cramps

OTHER SYMPTOMS

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_____

(Continued)

GENERAL SYMPTOMS (Check symptoms you currently have or have had in the past year.)

GENERAL
- ☐ Bruise easily
- ☐ Chills
- ☐ Dental problems
- ☐ Depression
- ☐ Difficulty sleeping
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Irritability
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats
- ☐ Tiredness
- ☐ Weight gain

GENITO-URINARY
- ☐ Blood in urine
- ☐ Cloudy urine
- ☐ Difficulty starting urination
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

SKIN
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Psoriasis
- ☐ Rash scars
- ☐ Sore that won't heal
- ☐ Yellow skin

GASTROINTESTINAL
- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR
- ☐ Blue or purple skin
- ☐ Blue or purple nail beds
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins
- ☐ Chest Pain

SURGERIES
_____
_____
_____
_____
_____

EYE, EAR, NOSE, THROAT
- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of coordination
- ☐ Loss of hearing
- ☐ Loss of smell
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision – flashes
- ☐ Vision – halos

RESPIRTORY
- ☐ Can't breathe while lying down
- ☐ Can't sleep while lying down
- ☐ Coughing up blood
- ☐ Dry cough
- ☐ Productive cough
- ☐ Shortness of breath
- ☐ Wheezing

SOCIAL HISTORY
- ☐ Alcohol use
- ☐ Chewing tobacco
- ☐ Drink coffee or tea
- ☐ Smoking
- ☐ Other

_____
_____

MEN only
- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

WOMEN only
- ☐ Abnormal pap smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last menstrual period_____
Date of last Pap Smear _____
Have you had a mammogram?_____
Are you pregnant?_____
Number of pregnancies_____
Number of deliveries_____

FAMILY HISTORY
- ☐ Cancer
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Stroke
- ☐ Other

_____
_____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I have made in the completion of this form.

Patient Signature_____ Date_____