

ABSHIRE CHIROPRACTIC

7992 Maurice Avenue
Maurice, LA 70555

Date _____

Patient Name _____ Birthdate _____

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

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

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

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 _____