GENERAL SYMPTOMS

Previously Presently

- ☐ ☐ Allergy (What) _____
- ☐ ☐ Bronchitis
- ☐ ☐ Chills
- ☐ ☐ Convulsions
- ☐ ☐ Dizziness
- ☐ ☐ Fainting
- ☐ ☐ Fatigue
- ☐ ☐ Fever
- ☐ ☐ Headache
- ☐ ☐ Loss of Sleep
- ☐ ☐ Loss of Weight
- ☐ ☐ Nervousness
- ☐ ☐ Neuralgia
- ☐ ☐ Night Sweats
- ☐ ☐ Numbness or Pain in Arms/Legs/Hands
- ☐ ☐ Wheezing

CARDIOVASCULAR

- ☐ ☐ High Blood Pressure
- ☐ ☐ Low Blood Pressure
- ☐ ☐ Pain Over Heart
- ☐ ☐ Poor Circulation
- ☐ ☐ Previous Heart Trouble
- ☐ ☐ Rapid Heart
- ☐ ☐ Slow Heart
- ☐ ☐ Strokes
- ☐ ☐ Swelling Ankles

GASTRO-INTESTINAL

Previously Presently

- ☐ ☐ Belching or Gas
- ☐ ☐ Colon Trouble
- ☐ ☐ Constipation
- ☐ ☐ Diarrhea
- ☐ ☐ Excessive Hunger
- ☐ ☐ Gall Bladder Trouble
- ☐ ☐ Hemorrhoids
- ☐ ☐ Jaundice
- ☐ ☐ Liver Trouble
- ☐ ☐ Pain Over Stomach
- ☐ ☐ Poor Appetite
- ☐ ☐ Poor Digestion
- ☐ ☐ Vomiting
- ☐ ☐ Vomiting Blood

MUSCLES & JOINTS

- ☐ ☐ Backache
- ☐ ☐ Foot Trouble
- ☐ ☐ Hernia
- ☐ ☐ Pain Between Shoulders
- ☐ ☐ Painful Tail Bone
- ☐ ☐ Stiff Neck
- ☐ ☐ Spinal Curvature
- ☐ ☐ Swollen Joints
- ☐ ☐ Tremors
- ☐ ☐ Twitching
- ☐ ☐ Weakness

EYE/EAR/ NOSE/THROAT

Previously Presently

- ☐ ☐ Asthma
- ☐ ☐ Crossed Eyes
- ☐ ☐ Deafness
- ☐ ☐ Earache
- ☐ ☐ Ear Discharges
- ☐ ☐ Ear Noises
- ☐ ☐ Enlarged Thyroid
- ☐ ☐ Frequent Colds
- ☐ ☐ Hay Fever
- ☐ ☐ Hoarseness
- ☐ ☐ Nasa Obstruction
- ☐ ☐ Nose Bleeds
- ☐ ☐ Pain in Eyes
- ☐ ☐ Poor Vision
- ☐ ☐ Sinusitis
- ☐ ☐ Sore Throats
- ☐ ☐ Tonsillitis

SKIN OR ALLERGIES

- ☐ ☐ Boils
- ☐ ☐ Bruising Easily
- ☐ ☐ Dryness
- ☐ ☐ Eczema
- ☐ ☐ Hives or Allergy
- ☐ ☐ Itching
- ☐ ☐ Sensitive Skin
- ☐ ☐ Skin Eruptions

RESPIRATORY

Previously Presently

- ☐ ☐ Chest Pain
- ☐ ☐ Chronic Cough
- ☐ ☐ Difficulty Breathing
- ☐ ☐ Spitting Blood
- ☐ ☐ Spitting Phlegm

GENITO-URINARY

- ☐ ☐ Bed Wetting
- ☐ ☐ Blood in Urine
- ☐ ☐ Frequent Urination
- ☐ ☐ Inability to Control Urine
- ☐ ☐ Kidney Infection
- ☐ ☐ Painful Urination
- ☐ ☐ Prostate Trouble

FOR WOMEN ONLY

- ☐ ☐ Cramps or Backaches
- ☐ ☐ Excessive Flow
- ☐ ☐ Hot Flashes
- ☐ ☐ Irregular Cycles
- ☐ ☐ Miscarriage
- ☐ ☐ Painful Periods
- ☐ ☐ Vaginal Discharge

Pregnant? No ☐ Yes ☐

List any accidents or falls and dates: ☐ Car _____ ☐ Recreational Vehicle _____

☐ Sports _____ ☐ School _____ ☐ Other _____

List any broken bones (fractures) or dislocations: _____

Ever on crutches? ☐ No ☐ Yes Why? _____

Have you ever had any spinal taps or spinal injections? ☐ Yes ☐ No When? _____

Have you ever had a lapse of memory? ☐ Yes ☐ No When? _____ Were you ever knocked unconscious? □ Yes □ No When? _____

Have you ever had X-rays taken? ☐ No ☐ Yes When? _____ By Whom? _____

For what ailments were these X-rays made? _____

Do you suffer from any condition other than that for which you are now consulting us? _____

Are you presently taking any medication -- prescription or over-the-counter? ☐ No ☐ Yes What drugs? _____

_____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that All American Chiropractic Health Center will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to All American Chiropractic Health Center will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize Dr. Jessie Smith to examine and treat my condition as he deems appropriate through the use of chiropractic health care, and I give authority for these procedures to be performed. It is understood that I am responsible for all bills incurred at this office. Dr. Jessie Smith and All American Chiropractic Health Center will not be held responsible for any pre-existing medically diagnosed condition nor for any medical diagnoses.

Patient's/Guardian's Signature _____ Date _____