Patient Name: ___________________________________

CURRENT COMPLAINTS:

CURRENT MEDICATIONS:

STREET/RECREATIONAL DRUGS:

SUPPLEMENTS:

TOBACCO / CIGARETTES:

ALCOHOL:

ALLERGIES:

SURGERIES:

SERIOUS INJURIES/ILLNESSES:

CHIROPRACTIC CARE:

EMPLOYMENT:

MOTHER:

FATHER:

HEADACHES:

MIGRAINE:

TMJ PROBLEMS:

EARS:

NAILS:

EYES:

SINUS:

POST NASAL DRIP:

THROAT:

COUGH:

URI:

HALITOSIS:

CANKERS:

COLD SORES:

UTI:

NECK STIFFNESS:

SHOULDER TENSION:

CHEILOSIS:

DRY MOUTH:

COLD HANDS/FEET:

SWEATY HANDS/FEET:

GUMS:

TEETH:

GLANDS:

DYSPHAGIA:

CHEST:

SHORTNESS OF BREATH:

DIGESTION:

INDIGESTION:

BOWELS:

FECAL CONSISTENCY:

HEMORRHOIDS:

CHERRY HEMANGIOMA:

+++++++++++++++++++++++++MALE ONLY+++++++++++++++++++++++++

PROSTATE:

+++++++++++++++++++++++++FEMALE ONLY+++++++++++++++++++++++++

PEACH FUZZ:

VAGINA:

VAGINAL DISCHARGE:

MENSES:

MENSES IRREGULAR:

MENSES FLOW:

MENSES CRAMPS:

FLUID:

MENSES ACNE:

PMS:

OVULATION:

PREGNANCIES:

BREAST FEEDING:

BREAST:

MENOPAUSE:

++

URINATION:

SLEEP INITIATION:

SLEEP MAINTENANCE:

EMOTIONAL WELL BEING:

APPETITE:

CRAVINGS:

STRESS LEVEL:

STRESS HANDLING:

PRIMARY STRESS:

ENERGY:

EXERCISE:

MEMORY:

COORDINATION:

CONCENTRATION:

SLOW HEALING:

TRAUMA: EMOTIONAL or PHYSICAL: