

Providence Family Chiropractic

Please answer the following:

1. Have you found anything that makes your problem **better?** _____
2. Have you found anything that makes your problem **worse?** _____
3. Do you have any problems you were born with? _____
4. Are you suffering from other disabling conditions? _____
5. Do your problems awaken you from sleep? _____
6. Has your problem affected your bodily functions? _____
7. Do you have a family history of:
Cancer Heart Stroke Arthritis Diabetes Other _____
8. List any medications you are taking and what you are taking them for. _____

Please circle any applicable region/symptom from your health history or current conditions.

- | | | | |
|------|--------------|-----------------|-------------------------|
| Head | Mouth/throat | Cancer | Immune System |
| Eyes | Lungs | Heart | Stomach/Digestion |
| Ears | Chest/Ribs | Joints/Bones | Female organ/menstrual |
| Nose | Weight Loss | Internal organs | Male organ/prostate |
| | | Thyroid | High/Low Blood pressure |

Fill in any information & approximate dates:

1. X-rays performed: _____
2. Spinal surgeries: _____
3. Accidents, falls, or injuries: _____
4. Broken bones / dislocations: _____
 - a) Fractures of the spine/vertebrae: _____
 - b) Sprains or strains: _____
5. Spinal (back) treatment/physical therapy: _____
6. Any other surgeries/operations: _____
7. Circle any test you have had:
MRI EKG EEG Myelogram Bone Scan EMG CAT SCAN Blood tests Other

Notice: Not all patients require X-rays to determine or verify a diagnosis, type and length of care. If your examination warrants x-ray analysis, the following office policy prevails:

1. All first visit charges are payable when services are rendered.
2. The fee paid for x-rays is for analysis only. The film itself is the property of this office and cannot be released.

Patient's Signature _____