

Below is a list of conditions that are indicators of possible nervous system interference. Chiropractic does not treat these problems. However, these conditions are often indicators of nervous system stress and possible subluxation.

CHECK ANY OF THE FOLLOWING CONDITIONS YOU HAVE HAD:

- | | | | |
|---|--|---|--------------------------------------|
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Influenza | INTAKE |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Cancer | <input type="checkbox"/> Obesity | <input type="checkbox"/> Coffee |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Tea |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Alcohol |
| <input type="checkbox"/> Eczema | | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Cigarettes |
| <input type="checkbox"/> Digestive Disorder _____ | | | <input type="checkbox"/> White Sugar |

CHECK ANY OF THE FOLLOWING CONDITIONS YOU HAVE HAD IN THE PAST SIX MONTHS:

MUSCULO-SKELETAL

- Low Back Pain
- Pain Between Shoulders
- Neck Pain
- Arm Pain
- Difficulty Chewing/Clicking Jaw
- General Stiffness

- Heartburn
- Black/Bloody Stool
- Colitis

GENITO-URINARY

- Bladder Trouble
- Painful/Excessive Urination

FEMALES ONLY:

When was your last period?

Are you pregnant?

- Yes No

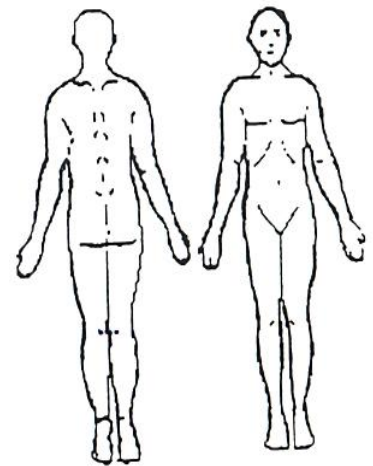
NERVOUS SYSTEM

- Nervous
- Numbness
- Dizziness
- Forgetfulness
- Confusion/Depression
- Fainting
- Convulsions
- Cold/Tingling Extremities
- Stress

C-V-R

- Chest Pain
- Short Breath
- Blood Pressure Problems
- Irregular Heartbeat
- Heart Problems
- Lung Problems/Congestion
- Varicose Veins
- Ankle Swelling
- Stroke

Please circle on the diagram the area of your discomfort



GENERAL

- Fatigue
- Allergies
- Loss of Sleep
- Headaches

EENT

- Vision Problems
- Dental Problems
- Sore Throat
- Earaches
- Hearing Difficulty/Ringing
- Stuffed Nose

GASTROINTESTINAL

- Poor/Excessive Appetite
- Excessive Thirst
- Frequent Nausea
- Vomiting
- Diarrhea
- Constipation
- Hemorrhoids
- Liver Problems
- Gall Bladder Problems
- Weight Trouble
- Abdominal Cramps
- Gas Bloating After Meals

MALE/FEMALE

- Menstrual Irregularity
- Menstrual Cramps
- Vaginal Pain/Infection
- Breast Pain/Lump
- Prostate/Sexual Dysfunction
- Other Problems
- _____
- _____

FAMILY HISTORY

The following members have the same or similar problem(s) as I do:

- Mother
- Father
- Brother
- Sister
- Spouse
- Child

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I hereby authorize the doctors at Health First Chiropractic and their assistants to administer care as they deem necessary. I also authorize the release of any information acquired in the course of my examination or care. I certify that the information in this entire intake form is true and correct.

Patient's (Parent or Guardian's) Signature _____