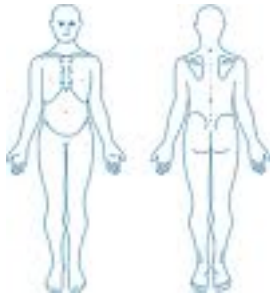


MEDICAL HISTORY



Pain Score 1 2 3 4 5 6 7 8 9 10

Describe Your Pain: Sharp Burning Aching
Tingling Numbness Dull
Other _____

Please shade in the area of the diagrams where the pain is located

Circle ANY previous testing:

X-Ray CT Scan MRI Physical Therapy Injections Surgery Chiropractor

Do you have or had any of the following medical conditions? (Circle all that apply)

Cancer	Heart Disease	Diabetes
High blood pressure	Stroke	Depression
Shortness of Breath	Kidney disease/stones	Urinary tract infection
Allergies	Asthma, hay fever	Hepatitis/Jaundice
Polio	Chronic Bronchitis	Emphysema
Anemia	Ulcers/Stomach Problems	Slow Healing
Thyroid Problems	Multiple Sclerosis	Tuberculosis
Fibromyalgia	Migraine Headaches	Epilepsy
Arthritis/gout	Hypoglycemia	HIV/AIDS
Chemical Dependency (alcohol/drugs)		Other _____

Please circle any of the following conditions that you may have recently noted:

Weight Loss/Gain	Nausea/Vomiting	Fatigue
Weakness	Fever/Chills/Sweats	Numbness/Tingling
Diarrhea	Fainting	Rash
Headaches	Change in Vision or Hearing	Insomnia
Pain at Night	Cramps in legs while Walking	

General Health

1. Prescription or over the counter medications you are currently taking _____

2. Do you smoke or chew tobacco? _____ If yes, how many packs a day? _____ For how long? _____

3. How much alcohol do you drink in the course of a week? _____

4. How much caffeine do you consume daily (soft drinks, coffee, tea, or chocolate?) _____

5. Are you on any special diet prescribed by a physician? _____

6. Do you have a pacemaker, transplanted organ, joint replacements, or metal implants? _____