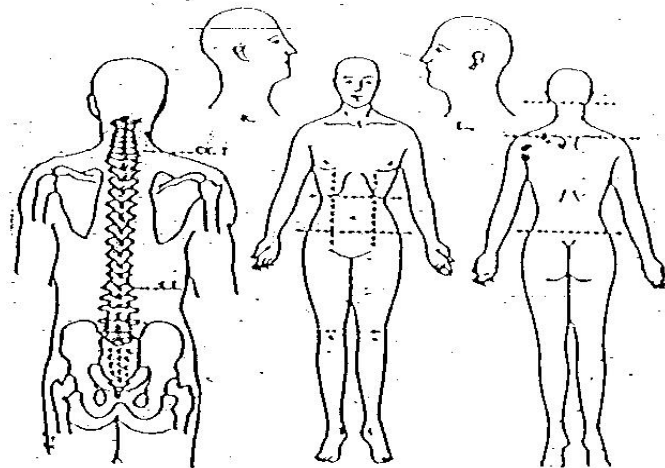
INITIAL HEALTH STATUS

Patient Name:_________________________________ **Date:**____________________

In the diagrams below, mark the areas of the body, using the symbols, where you have experienced any of the following symptoms **this past week:**

Symbols

ACHING	**XXXX**
BURNING	**^^^^**
STABBING	**////**
PINS & NEEDLES	**0000**
NUMBNESS	**-----------**



Please check all of the following that apply to you: ☐ None Apply

- ☐ Recent Fever
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Stroke (date)___________________________
- ☐ Corticosteroid Use (cortisone, prednisone, etc.)
- ☐ Taking Birth Control Pills
- ☐ Dizziness/Fainting
- ☐ Numbness in Groin/Buttocks
- ☐ Cancer/Tumor (explain)___________________
- ☐ Osteoporosis
- ☐ Epilepsy/Seizures
- ☐ Other Health Problems (explain)____________

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- ☐ Prostate Problems
- ☐ Menstrual Problems
- ☐ Urinary Problems
- ☐ Currently Pregnant, #weeks_________, #births____
- ☐ Abnormal Weight ☐ Gain ☐ Loss
- ☐ Marked Morning Pain/Stiffness
- ☐ Pain Unrelieved by Position or Rest
- ☐ Pain at Night
- ☐ Visual Disturbances
- ☐ Surgeries_____________________________________

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- ☐ Medications__________________________________

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- ☐ History of Alcohol Use ☐ History of Tobacco Use

Family History: ☐Cancer ☐Diabetes ☐High Blood Pressure ☐Heart Problems/Stroke ☐Rheumatoid Arthritis

I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my chiropractor may need to contact my physician if my condition needs to be co-managed. Therefore, I give authorization to my chiropractor to contact my physician, if necessary.

Patient Signature____ **Date**__________________