

GOALS FOR MY CARE

People see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others for correction of whatever is malfunctioning in their bodies. Your Doctor will weigh your needs and desires when recommending your treatment program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

- Relief Care** — Symptomatic relief of pain or discomfort
- Corrective Care** — Correcting and relieving the cause of the problem as well as the symptoms
- Comprehensive Care** — Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic care.
- I want the Doctor to select the type of care appropriate for my condition.

Patient's Signature

Date

MEDICATIONS I NOW TAKE

- | | |
|-----------------------------------------------------------|-----------------------------------------|
| <input type="checkbox"/> Nerve Pills | <input type="checkbox"/> Stimulants |
| <input type="checkbox"/> Pain Killers (including Aspirin) | <input type="checkbox"/> Blood Thinners |
| <input type="checkbox"/> Muscle Relaxers | <input type="checkbox"/> Tranquilizers |
| <input type="checkbox"/> Blood Pressure Medicine | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Insulin | <input type="checkbox"/> _____ |

HEALTH HABITS

- | | No | Yes |
|----------------------------|--------------------------------------|------------------------------------------------------------------|
| Do you smoke? | <input type="checkbox"/> | <input type="checkbox"/> ____ packs/day |
| Do you drink alcohol? | <input type="checkbox"/> | <input type="checkbox"/> ____ drinks/day |
| Do you drink coffee? | <input type="checkbox"/> | <input type="checkbox"/> ____ cups/day |
| Do you exercise regularly? | <input type="checkbox"/> No | <input type="checkbox"/> Moderate <input type="checkbox"/> Daily |
| Do you wear | <input type="checkbox"/> Heel Lifts | <input type="checkbox"/> Sole Lifts |
| | <input type="checkbox"/> Inner Soles | <input type="checkbox"/> Arch Supports |

HEALTH CONDITIONS

Please check each of the diseases or conditions that the patient has now or has had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan and the possibility of being accepted for care.

- | | | |
|--------------------------------------------------------------|------------------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> Severe or Frequent Headaches | <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Heart Surgery/
Pacemaker | <input type="checkbox"/> Kidney Problems |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Loss of Sleep | <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Pain Between the Shoulders | <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Chemotherapy |
| <input type="checkbox"/> Frequent Neck Pain | <input type="checkbox"/> Asthma | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Numbness or Pain in Arms/Legs/Hands | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Lower Back Problems | <input type="checkbox"/> Alcohol/Drug Abuse | <input type="checkbox"/> Psychiatric Problems |
| <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Ulcers/Colitis | <input type="checkbox"/> HIV/Aids | |
| <input type="checkbox"/> Heart Attack/Stroke | <input type="checkbox"/> Diabetes | |
| | <input type="checkbox"/> Tuberculosis | |

For Women

- | | | |
|------------------------------------|------------------------------|-----------------------------|
| Are you pregnant? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Are you nursing? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Are you taking birth control? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you experience painful periods? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have irregular cycles? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have breast implants? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |