WELCOME TO GUILDFORD CHIROPRACTIC

Full Name:_____**Date:**_____
(Last) (First) (Initial)

Please review and check ( ) the following conditions which are presently a problem and mark with a ( ) the conditions which have previously been a problem. Thank you.

MUSCLE/SKELETAL SYSTEM
____ Low Back
____ Middle Back
____ Neck
____ Shoulder
____ Elbow
____ Wrist
____ Hip
____ Knee
____ Foot
____ Ankle
____ Swollen joints
____ Painful joints
____ Stiff joints
____ Sore muscles
____ Weak muscles
____ Walking problems
____ Ruptures
____ Broken bones
____ Bone diseases

GENITO-URINARY SYSTEM
____ Bladder trouble
____ Excessive urine
____ Scanty urination
____ Painful urination
____ Difficulty initiating urine stream
____ Discoloured urine
____ Blood in urine

NERVOUS SYSTEM
____ Numbness
____ Loss of feeling
____ Paralysis
____ Dizziness
____ Fainting
____ Headaches
____ Muscle twitching
____ Confusion
____ Depression
____ Loss of sleep

CARDIO-VASCULAR/ RESPIRATORY SYSTEM
____ Chest pain
____ Pain over heart
____ Difficulty breathing
____ Persistent cough
____ Coughing phlegm
____ Coughing blood
____ Rapid heartbeat
____ High blood pressure
____ Low blood pressure
____ Heart problems
____ Lung problems
____ Varicose veins

EYE, EAR, NOSE AND THROAT
____ Eye strain
____ Eye inflammation
____ Vision problems (specify) _____
____ Ear pain
____ Ear discharge
____ Ringing in ears
____ Hearing loss
____ Nose bleeding
____ Nose discharge
____ Difficulty breathing through nose
____ Sore gums
____ Dental problems
____ Clicking jaw
____ Enlarged thyroid
____ Sore mouth
____ Asthma
____ Hoarseness
____ Difficult speech
____ Sinus condition
____ Allergies (specify) _____

SKIN
____ Rashes
____ Bruises easily
____ Boils
____ Hives

GASTRO-INTESTINAL SYSTEM
____ Poor appetite
____ Excessive hunger
____ Difficulty chewing
____ Excessive thirst
____ Nausea
____ Vomiting food
____ Vomiting blood
____ Indigestion
____ Abdominal pain
____ Excessive gas
____ Diarrhea
____ Constipation
____ Black stool
____ Bloody stool
____ Hemorrhoids
____ Liver trouble
____ Gall bladder problems
____ Water retention
____ Weight trouble
____ Jaundice

FEMALE SYSTEM
____ Vaginal discharge
____ Vaginal bleeding
____ Vaginal pain
____ Breast pain
____ Lumps on breast
____ Painful menses

Have you ever had any major falls, accidents or injuries? Yes No
If Yes, please explain (give date)_____
_____

Have you ever had, or currently have, any major illness or disease? Yes No
If Yes, please explain (give date)_____
_____

Have you ever had any surgery? Yes No
If Yes, please explain (give date)_____
_____

Are their any major diseases in your family history? Yes No
If Yes, what?_____

Are you currently taking medication? Yes No
If Yes, please give type and reason_____
_____

Are you a smoker? Yes No