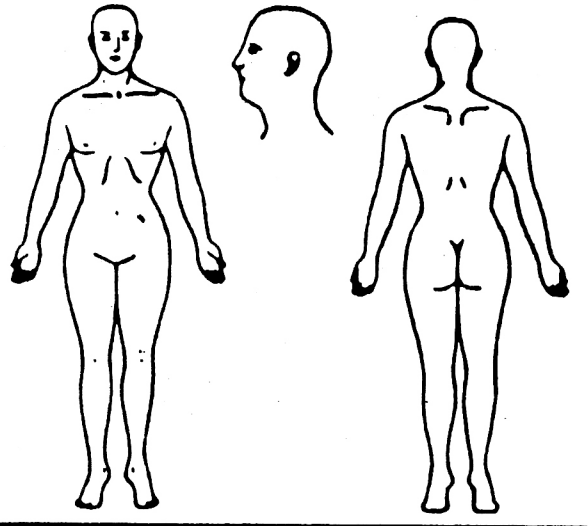


Please mark your areas of pain on the figures shown below.



Date \_\_\_\_\_

PATIENT SYMPTOMS

Patient's Present Symptoms \_\_\_\_\_

\_\_\_\_\_

Additional Symptoms \_\_\_\_\_

\_\_\_\_\_

Recent Falls \_\_\_\_\_ Recent Accidents \_\_\_\_\_

Surgery Date \_\_\_\_\_ Other Illnesses \_\_\_\_\_

Medication Being Taken \_\_\_\_\_ Date Last Physical \_\_\_\_\_

First Chiropractic Treatment: [ ] Yes [ ] No

Patient's Comments \_\_\_\_\_

\_\_\_\_\_

Check Symptoms You Have Noticed:

- |                      |                         |                     |                   |
|----------------------|-------------------------|---------------------|-------------------|
| [ ] Headache         | [ ] Dizziness           | [ ] Light Hurt Eyes | [ ] Diarrhea      |
| [ ] Neck Pain        | [ ] Head Seems Heavy    | [ ] Loss of Memory  | [ ] Feet Cold     |
| [ ] Neck Stiff       | [ ] Pins/Needles - Arms | [ ] Ears Ring       | [ ] Hands Cold    |
| [ ] Sleeping Problem | [ ] Pins/Needles - Legs | [ ] Face Flushed    | [ ] Stomach Upset |
| [ ] Back Pain        | [ ] Numbness in Fingers | [ ] Buzzing in Ears | [ ] Constipation  |
| [ ] Nervousness      | [ ] Numbness in Toes    | [ ] Loss of Balance | [ ] Cold Sweats   |
| [ ] Tension          | [ ] Shortness of Breath | [ ] Fainting        | [ ] Fever         |
| [ ] Irritability     | [ ] Fatigue             | [ ] Loss of Smell   | [ ] High Blood    |
| [ ] Chest Pain       | [ ] Depression          | [ ] Loss of Taste   | Pressure          |

Additional Symptoms \_\_\_\_\_

\_\_\_\_\_

Patient's First Name \_\_\_\_\_ Last Name \_\_\_\_\_