Patient Name _____ Date _____

PLEASE CHECK ALL THAT APPLY. Have you ever had any of the following?

CONSTITUTIONAL	☐Fever	☐Night Sweats	☐Unexplained Weight Loss	☐Recent Infection	☐Other
EYES - EARS - MOUTH	☐ Sudden Visual Change/loss		☐Sudden Hearing Change /loss	☐Difficulty Swallowing	
RESPIRATORY	☐ Chronic Cough	☐ Sleep Apnea	☐ Pulmonary Embolism	☐ Asthma	☐ Tuberculosis
	☐ Emphysema	☐Pneumonia	☐ Difficulty Breathing	☐ COPD	☐ Other
CARDIOVASCULAR	☐ Chest Pain	☐Heart Failure	☐ Irregular Heartbeat	☐ Pacemaker	☐ High Blood Pressure
	☐ Heart Attack	☐Poor Circulation	☐ Peripheral Vascular Disease		☐ Other
NEUROLOGICAL	☐ Stroke/TIA	☐ Headaches	☐Dizziness	☐Seizures	☐ Memory Loss
	☐ Neuropathy	☐ Cerebral Palsy	☐Parkinson's /Tremors	☐ MS	☐ Loss of Sense of Smell
	☐One sided Weakness (face/body)		☐Decreased Feeling (face/body)		☐Vertigo ☐ Other
ENDOCRINE	☐Diabetes	☐Cancer	☐Thyroid Disease	☐Hormone Replacement Therapy	
	☐High Cholesterol	☐Hot Flashes	☐Decreased Sexual Function	☐ Other	
RENAL NEPHROLOGY	☐ Kidney Disease	☐Kidney Stones	☐Kidney Failure/Dialysis	☐Burning w/ Urination	
	☐Blood in Urine	☐Prostate Disease	☐Incontinence	☐Difficulty w/Urination	
	☐Other		☐STD / Venereal Disease	☐ Urinary Tract Infection / Bladder	
GASTROINTESTINAL STOMACH	☐Bleeding	☐Nausea /Vomiting	☐Diarrhea	☐Ulcers	☐Frequent Abdominal Pain
	☐Heartburn	☐Acid Reflux - GERD	☐Hiatal Hernia	☐Constipation	☐Hepatitis /Liver Disease
	☐Vomiting Blood	☐Pancreatic Disease	☐Bloody or Black Stool	☐IBS /Crohns	☐Other
BLOOD DISORDERS	☐Anemia	☐Hemophilia	☐Blood Clot Disorders	☐HIV Positive	☐Enlarged Lymph Nodes
	☐Sickle Cell Anemia	☐Anticoagulant Thpy	☐Anemia	☐Other	
SKIN DISORDERS	☐Significant Rashes	☐Psoriasis	☐Skin Ulcers	☐Skin Grafts	☐Significant Burns
MUSCULOSKELETAL BONE & JOINT	☐Arthritis	☐Broken Bones	☐Ankylosing Spondylitis	☐Lupus	☐Gout ☐Spinal Fracture
	☐Joint Replacement	☐Painful Swollen Joints	☐Scoliosis	☐Spinal Surgery	☐Other
PSYCHO-SOCIAL DISORDERS	☐Depression	☐Anxiety	☐Difficulty Sleeping	☐Schizophrenia	☐Bipolar Disorder
	☐Suicidal/Homicidal ideas		☐Alcohol / Drug Dependence		☐Other

1. Please rate your health on a scale of 0-10 0 = least healthy 10 = healthy

0☐ 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐

2. How important is your health to you? 0 = Not very 10 = very

0☐ 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐

3. Do you feel like any of the following are keeping you from being healthier? ☐ Motivation ☐ Information Overload ☐ Lack of Information ☐ Not Sure Where to Start ☐ Genetics ☐ Lack of Interest

4. If someone could help you find solutions and explain how you are doing health wise, how interested would you be ?

0=Not Interested 10=Very Interested

0☐ 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐

5. Is anyone currently helping you to manage your health? ☐Yes ☐No

Comments:

I certify that this information is true and correct to the best of my knowledge. I hereby authorize Prebish Chiropractic Centre to provide chiropractic care in accordance with this state's statutes. If Insurance is billed I authorize payment to Prebish Chiropractic Centre for services rendered.

Signature of Patient or Guardian _____ Date _____