

Francis Chiropractic

Name _____

Date _____

Email _____

1. Family Physician _____ Weight _____ / Height _____

2. List any health conditions or illnesses that you are currently being treated for:

3. Have you had any broken bones? What? When?

4. Have you had any past auto accidents, work injuries or traumas? What?

When:

5. Smoker? Yes no ex-smoker

6. Have you had any surgeries? What? When?

7. Do you have?

Please list Medicines being taken for each condition:

Y N High Blood Pressure

Y N Heart Disease

Y N High Cholesterol

Y N Diabetes

Y N Cancer

Y N Stroke

Y N Asthma/ Emphysema

Y N Hepatitis/HIV

Y N Arthritis

Other Medications/Reason

Allergies to medication:

8. General

___ Weight loss

___ Poor sleep

___ Strong thirst

___ Night sweats

___ Fever

___ Fatigue

___ Poor balance

Gastrointestinal

___ Nausea

___ Diarrhea

___ Constipation

___ Black stools

___ Blood In stool

___ Reflux

___ Gallbladder trouble

___ Colitis

___ Abdominal pain/cramps

___ Liver disease

___ Heartburn

___ Ulcers

___ Diverticulitis

___ Appendicitis

___ Food allergies

___ Hiatal hernia

Neurological

___ Dizziness

___ Seizures

___ Numbness / Tingling

___ Depression

___ Anxiety

___ Concussions

___ Other neurological disorders

___ Headaches

Cardiovascular

___ Dizziness

___ High blood pressure

___ Poor circulation

___ Swelling in feet

___ Chest pain

___ Hardening of arteries

___ Irregular heart beat

___ Blood clots

___ Other cardiovascular

Head, Eyes, Ears, Throat

___ Migraines / Headaches

___ Eye pain or strain

___ Blurry vision

___ Ringing in ears

___ Sinus problems

___ Facial pain / numbness

___ Grinding teeth

___ TMJ

___ Chronic earaches

___ Chronic headcolds

___ Hearing loss

Respiratory

___ Asthma / allergies

___ Difficulty breathing

Urinary

___ Kidney/bladder infections

___ Blood in urine

___ Pain upon urination

___ Urgency to urinate

Coughing up blood
 Other lung problem

Prostate problems
 Any other genital/urinary problems _____