NEWCOMB CHIROPRACTIC CLINIC

Name: _____ Date: _____ Referred By: _____

1. Briefly describe your symptoms: _____

_____

2. When did your symptoms start? _____
3. How did your symptoms start? _____
4. Rate you pain from 0-10 with 0 being no pain and 10 being the worst pain possible:.

⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

Please check if you currently or previously have had the following health conditions:

Past	Present		Past	Present	
❑	❑	Neck Pain	❑	❑	Difficulty in Swallowing
❑	❑	Shoulder Pain	❑	❑	Heartburn/Indigestion
❑	❑	Pain in Upper Arm or Elbow	❑	❑	Dermatitis/Eczema/Rash
❑	❑	Hand Pain	❑	❑	Depression
❑	❑	Upper Back Pain	❑	❑	Aortic Aneurysm
❑	❑	Low Back Pain	❑	❑	High Blood Pressure
❑	❑	Pain in Upper Leg or Hip	❑	❑	Angina
❑	❑	Pain in Lower Leg or Knee	❑	❑	Heart Attack
❑	❑	Pain in Ankle or Foot	❑	❑	Stroke
❑	❑	Jaw Pain	❑	❑	Asthma
❑	❑	Swelling/Stiffness of Joint(s)	❑	❑	Cancer
❑	❑	Fainting, Visual Disturbances, Nausea	❑	❑	Prostate Problems
❑	❑	Convulsions	❑	❑	Anorexia
❑	❑	Dizziness	❑	❑	Blood Disorder
❑	❑	Headache	❑	❑	Emphysema (chronic lung disorders)
❑	❑	Muscular Incoordination	❑	❑	Arthritis
❑	❑	Tinnitus (Ear Noises)	❑	❑	Diabetes
❑	❑	Rapid Heart Beat	❑	❑	Stomach Disorders
❑	❑	Chest Pains	❑	❑	Bladder Infection
❑	❑	Loss of Appetite	❑	❑	Kidney Disorders
❑	❑	Abnormal Weight Gain	❑	❑	Irritable Colon
❑	❑	Abnormal Weight Loss	❑	❑	HIV/AIDS
❑	❑	Excessive Thirst	Other_____		
❑	❑	Chronic Cough			
❑	❑	Chronic Sinusitis	❑	❑	Alcohol Use
❑	❑	General Fatigue	❑	❑	Birth Control Use
❑	❑	Irregular Menstrual Flow	**Please list any past surgery:**		
❑	❑	Profuse Menstrual Flow	_____		
❑	❑	Breast Soreness/Lumps	_____		
❑	❑	Vaginal Discharge	_____		
❑	❑	PMS	_____		
❑	❑	Loss of Bladder Control	Has any of your siblings or parents had the following:		
❑	❑	Painful Urination	Yes	No	
❑	❑	Frequent Urination	❑	❑	Bone/Joint Fracture or disease
❑	❑	Abdominal pain	❑	❑	Cancer
❑	❑	Constipation/irregular bowel habits	❑	❑	Heart disease
			❑	❑	High Blood Pressure
			❑	❑	Diabetes