DAVEN L. SPENCER, D.C.

Dedicated to Quality Chiropractic Care, NOT Quantity Care!

SYMPTOMS

NAME:_____ DATE:_____

CHECK ANY OF THE FOLLOWING YOU HAVE HAD:

___Appendicitis ___Tuberculosis ___Cancer ___Epilepsy ___Diabetes
___Arthritis ___Pneumonia ___Chicken Pox ___Venereal Infection ___Anemia
___Alcoholism ___Goiter ___Polio ___Whooping Cough ___Heart Disease
___Asthma ___Mental Disorder (including Anxiety, Depression, Bipolar, etc.)

CHECK ANY OF THE FOLLOWING YOU PRESENTLY HAVE OR HAVE HAD RECENTLY:

HEAD:

___Headache
___Head feels heavy
___Loss of memory
___Light-headed
___Fainting
___Light bothers eyes
___Loss of smell
___Loss of taste
___Dizziness
___Loss of hearing
___Pain in ears
___Ringing in ears
___Visual Problems
___Jaw pain/clicking

GENERAL:

___Nervousness
___Irritable
___Depressed
___Fatigue
___Loss of sleep
___Loss of weight
___Fever (unexplained)

CHEST:

___Chest pain
___Shortness of breath
___Heart problems
___Lung problems
___High blood pressure

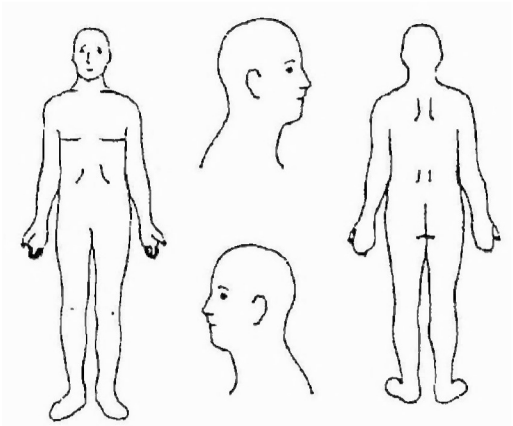
ABDOMEN:

___Nervous stomach
___Nausea
___Gas
___Constipation
___Diarrhea
___Vomiting
___Irritable Bowel

MALE/FEMALE:

___Menstrual cramping
___Breast pain/lumps
___Prostate problems

PLEASE MARK YOUR AREAS OF PAIN ON THE FIGURES BELOW:



MUCULOSKELETAL:

___Neck pain
___Mid back pain
___Low back pain
___Pain between shoulders
___Shoulder pain
___Pain in buttock
___Pain in hip joint
___Pain down leg
___Tingling in legs
___Numbness in legs
___Feet/Hands feel cold
___Swollen ankles/feet
___Knee pain
___Loss of strength in arms or legs
___Pain in arms/hands
___Tingling in arms/hands
___Numbness in arms/hands
___Difficulty walking
___Difficulty chewing

MEDICATIONS (Please List):

_____

_____

_____

SURGERIES (Please List):

_____

_____

WHICH SYMPTOMS BROUGHT YOU HERE TODAY AND **HOW DID THEY START?** Continue on back of form if necessary:

_____

_____

_____

GENERAL INFORMATION

Height_____ Weight_____ Have you had X-rays before: ___Yes ___No Date taken:_____
Where were X-rays taken:_____What body part: _____
WOMEN ONLY: Are you pregnant? ___Yes ___No If yes, Due Date:_____Date of Last Period:_____