

Welcome To All Ways Family Health Center, P.A.

Practice Member Information

Whom may we thank for your referral? _____

Name _____		Sex <input type="checkbox"/> M <input type="checkbox"/> F	Today's Date _____
Address _____		Occupation _____	
City _____	State _____	Zip _____	Work Phone _____
Home Phone _____	Cell Phone _____	Email _____	
Date of Birth _____	Age _____	Social Security # _____	
Circle: Single Married Divorced Separated Widowed		Spouse's Name _____	
Children's Names & Ages _____			
Have they ever been adjusted? Yes No			

Do you have current health concerns? Yes No Or are you in for a well check? Yes No

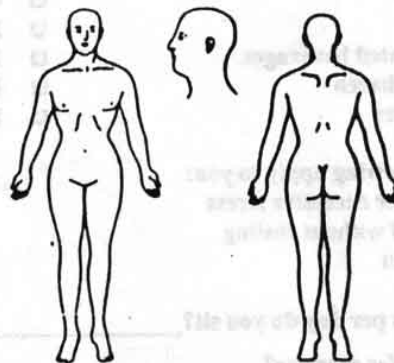
Please check if you have any of the following symptoms: C = Current Problem P = Previous Condition

- | C P | C P | C P |
|---|--|---|
| <input type="checkbox"/> <input type="checkbox"/> Arm/shoulder pain | <input type="checkbox"/> <input type="checkbox"/> Feet/toe numbness | <input type="checkbox"/> <input type="checkbox"/> Neck pain |
| <input type="checkbox"/> <input type="checkbox"/> Back pain | <input type="checkbox"/> <input type="checkbox"/> Hand/finger numbness | <input type="checkbox"/> <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> <input type="checkbox"/> Eyes burning | <input type="checkbox"/> <input type="checkbox"/> Headaches | <input type="checkbox"/> <input type="checkbox"/> Sleep difficulty |
| <input type="checkbox"/> <input type="checkbox"/> Fatigue | <input type="checkbox"/> <input type="checkbox"/> Migraines | <input type="checkbox"/> <input type="checkbox"/> Stomach problems |
| <input type="checkbox"/> <input type="checkbox"/> Ear ringing | <input type="checkbox"/> <input type="checkbox"/> Irritability | <input type="checkbox"/> <input type="checkbox"/> Tension |
| <input type="checkbox"/> <input type="checkbox"/> Back stiffness | <input type="checkbox"/> <input type="checkbox"/> Jaw problems | <input type="checkbox"/> <input type="checkbox"/> Vertigo |
| <input type="checkbox"/> <input type="checkbox"/> Balance impaired | <input type="checkbox"/> <input type="checkbox"/> Joint pain | <input type="checkbox"/> <input type="checkbox"/> Asthma |
| <input type="checkbox"/> <input type="checkbox"/> Chest pain | <input type="checkbox"/> <input type="checkbox"/> Memory loss | <input type="checkbox"/> <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> <input type="checkbox"/> Dizziness | <input type="checkbox"/> <input type="checkbox"/> Reflux (heartburn) | |

WOMEN ONLY: Is there are chance that you could be pregnant? Yes No

If none of the above conditions or symptoms applies to you, please indicate any other symptoms, health concerns or information Dr. Higgins should know.

Please Mark Your Areas of Pain on the Figures Below



List your "top" health symptom complaints:

1. _____
2. _____
3. _____
4. _____
5. _____

Is this current condition due to an auto accident? Yes No Date of accident _____

Is it work related? Yes No Date of injury _____

How long have you had this condition? _____ Is this the first time? Yes No

Does this condition interfere with your: (circle if appropriate) work sleep daily routine recreation

Have you had standing spinal x-rays in the last two years? Yes No Where? _____

Name of previous chiropractor: _____

Results: _____

Other Drs. Consulted for this condition: _____

Results: _____

Describe any other health conditions treated in the last year. _____

List any other previously diagnosed conditions: _____

Indicate any previous surgeries and date/s performed: _____

Which of the following medications are you taking:

- Antacids
- Antibiotic/antifungal
- Antidepressants
- Antidiabetic/insulin
- Aspirin/Tylenol
- Chemotherapy/radiation
- Cortisone/anti-inflammatory
- Diet pills
- Heart medication
- High blood pressure
- Hormones
- Laxatives
- Oral contraceptives
- Relaxant/sleeping pills
- Steroids
- Thyroid medication
- Ulcer medication

List any other medications and/or homeopathic and nutritional supplements are you taking.

Which of the following do you eat, drink or use:

- Alcohol
- Candy
- Carbonated beverages
- Chew tobacco
- Cigarettes
- Coffee
- Diet pop
- Purified water
- Fast food restaurants
- Fried foods
- Luncheon meats
- Margarine
- Saccharine/Aspartame (Sweet & Low etc.)

Which of the following apply to you:

- Are under excessive stress
- Salt food without tasting
- Diet often
- Do not exercise regularly
- Are exposed to chemicals at work
- Are exposed to cigarette smoke

How many hours per day do you sit? _____ How often do you exercise? _____

What do you do for exercise? _____

Do you sleep on your (circle one) back side stomach ? _____

