



13. How are your eating habits?  Professionally recommended diet  Good  Fair  Poor  
Are you interested in having a nutritional analysis/consultation?  yes  no

14. What is your present general stress level:  High  Moderate  Minimal  None

### Past or Present Symptoms/Conditions

Below is a list of symptoms and conditions. Please check the box indicating whether this applies to the past or present.

	past	present
Neck pain.....	<input type="checkbox"/>	<input type="checkbox"/>
Shoulder pain.....	<input type="checkbox"/>	<input type="checkbox"/>
Arm/elbow pain.....	<input type="checkbox"/>	<input type="checkbox"/>
Hand pain.....	<input type="checkbox"/>	<input type="checkbox"/>
Upper back pain.....	<input type="checkbox"/>	<input type="checkbox"/>
Lower back pain.....	<input type="checkbox"/>	<input type="checkbox"/>
Hip/thigh pain.....	<input type="checkbox"/>	<input type="checkbox"/>
Knee/leg pain.....	<input type="checkbox"/>	<input type="checkbox"/>
Ankle/foot pain.....	<input type="checkbox"/>	<input type="checkbox"/>
Jaw pain.....	<input type="checkbox"/>	<input type="checkbox"/>
Headaches.....	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness.....	<input type="checkbox"/>	<input type="checkbox"/>

	past	present
High blood pressure.....	<input type="checkbox"/>	<input type="checkbox"/>
Heart condition.....	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory condition.....	<input type="checkbox"/>	<input type="checkbox"/>
Digestive problem.....	<input type="checkbox"/>	<input type="checkbox"/>
Menstrual problem.....	<input type="checkbox"/>	<input type="checkbox"/>
Sinus problem.....	<input type="checkbox"/>	<input type="checkbox"/>
Asthma.....	<input type="checkbox"/>	<input type="checkbox"/>
Skin condition.....	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes.....	<input type="checkbox"/>	<input type="checkbox"/>
Cancer.....	<input type="checkbox"/>	<input type="checkbox"/>
Allergies.....	_____	
Surgeries.....	_____	

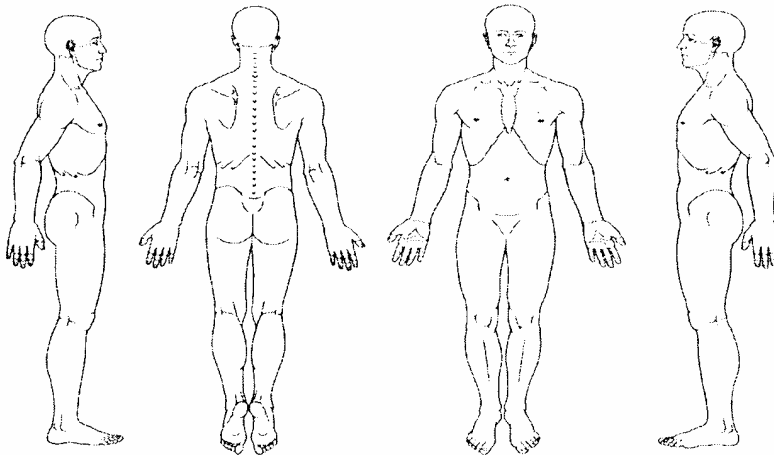
Tobacco use:  
 past  present  
 occasional  
 moderate  heavy

Alcohol use:  
 past  present  
 occasional  
 moderate  heavy

Caffeine use:  
 past  present  
 occasional  
 moderate  heavy

Family History \_\_\_\_\_

Using the figures below, please shade in the areas where you have pain or any other symptoms.



### Consent for Treatment

I hereby authorize the treating physician and whomever he may designate as his assistant(s) to perform diagnostic tests, including but not limited to radiographs, and to administer treatment as necessary. I authorize the release of any medical or other information necessary to process this claim. I also request payment of medical benefits to be paid directly to the treating physician for services rendered.

### Patient's Signature

\_\_\_\_\_ Date \_\_\_\_\_

### Guardian's Signature (if minor)

\_\_\_\_\_ Date \_\_\_\_\_