

GOLDEN SUN CHIROPRACTIC WELLNESS CENTER, PLLC

PATIENT NAME: _____

INITIAL EXAM DATE: _____

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FAMILY HISTORY

(Father, Mother, Brother, Sister)
Circle one for each question:
(a) Presently Has
(b) Previously Had

1. a - b Allergies
2. a - b Arthritis
3. a - b Asthma
4. a - b Cancer
5. a - b Diabetes
6. a - b Emphysema
7. a - b Heart Disease
8. a - b High Blood Pressure
9. a - b Hypoglycemia
10. a - b Kidney Disease
11. a - b Mental Illness
12. a - b Polio or MS
13. a - b Stroke
14. a - b Tuberculosis

PAST HISTORY

(Check mark if you have had in the past or presently have any of the following disorders)

1. () Alcoholism
 2. () Allergies
 3. () Arthritis
 4. () Asthma
 5. () Cancer
 6. () Chicken Pox
 7. () Colitis
 8. () Diabetes
 9. () Diverticulitis
 10. () Drug Abuse
 11. () Emphysema
 12. () Epilepsy
 13. () Gall Bladder Problems
 14. () Gonorrhea
 15. () Heart Disease
 16. () Hepatitis
 17. () Hernia
 18. () HIV/AIDS
 19. () Kidney Problems
 20. () Liver Problems
 21. () Meningitis
 22. () Mental Illness
 23. () Mumps
 24. () Pneumonia
 25. () Polio or MS
 26. () Rheumatic Fever
 27. () Syphilis
 28. () Thyroid Imbalance
 29. () Tuberculosis
 30. () Ulcers
 31. () Other
- _____

(Read carefully through the following lists. Check those items which presently apply to you)

GENERAL INFORMATION

1. () Anemia
 2. () Bad Breath
 3. () Body Odor Problems
 4. () Convulsions
 5. () Dental Problems
 6. () Dizziness/Loss of Balance
 7. () Fainting
 8. () Fatigue/Run Down
 9. () Fevers
 10. () Insomnia
 11. () Irritable
 12. () Nervous/Depressed
 13. () Night Sweats
 14. () Skin Disorders
 15. () Slow Healing Cuts/Bruises
 16. () Tumors, Cysts, Lumps, or Odd Swellings
 17. () Tremors
 18. () Twitches or Tics
 19. () Weight Gain/Loss
 20. () Migraines
 21. () Other
- _____

EYE, EAR, NOSE, THROAT

1. () Vision Impairment
 2. () Night Blindness
 3. () Color Blindness
 4. () Spots In Front Of Eyes
 5. () Eye Pain
 6. () Contact Lenses/Glasses
 7. () Cataracts
 8. () Deafness
 9. () Earache
 10. () Hearing Aid
 11. () Ringing In Ears
 12. () Frequent Colds
 13. () Cough
 14. () Frequent Headaches
 15. () Grinding Teeth
 16. () Nose Bleeds
 17. () Frequent Sore Throats
 18. () Sinusitis
- Any other head or neck problems?

HEART/LUNGS

1. () Chest Pain
 2. () Cough Up Phlegm
 3. () Difficult Breathing
 4. () Bloody Sputum
 5. () High/Low Blood Pressure
 6. () Pacemaker
 7. () Pain Over Heart
 8. () Rapid Heartbeat
 9. () Varicose Veins
- _____

GASTROINTESTINAL

1. () Poor/Excessive Appetite
 2. () Excessive Thirst
 3. () Indigestion
 4. () Gas, Bloating
 5. () Diarrhea/Constipation
 6. () Nausea
 7. () Vomiting
 8. () Abnormal Stools
 9. () Abdominal Pains
 10. () Nervous Stomach
 11. () Stomach Cramps
 12. () Hemorrhoids
- _____

FEMALE REPRODUCTIVE

1. () Irregular or Profuse Flow
2. () Cessation of Flow
3. () Cramping
4. () Breast Soreness
5. () Vaginal Discharge/Pain
6. () Menopausal Problems
7. () Period Between Menses
8. () Clots
9. () Vaginal Sores
10. () Breast Lumps
11. () Changes In Body/Psyche Prior To Menstruation
12. Date Last Menses: _____
13. Age of First Menses: _____
14. Date Last Pap Test: _____
15. Date Last Complete Gynecological Exam: _____
16. # Of Pregnancies: _____
17. # Of Births: _____
18. # Of Premature Births: _____
19. # Of Miscarriages: _____
20. # Of Abortions: _____
21. Have you taken or do you take birth control pills?
Yes ____ No ____
If yes, what kind and how long? _____

23. Have you or do you use a birth control device?
Yes ____ No ____
If yes, what kind and how long? _____

SKIN AND HAIR

1. () Rashes
2. () Itching
3. () Dandruff
4. () Change In Hair Or Skin Texture
5. () Ulcerations
6. () Eczema
7. () Loss Of Hair

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- 8. () Hives
 - 9. () Pimples
 - 10. () Recent Moles
 - 11. () Sun Burn - 2nd /3rd Degree.
- Any other hair or skin problems?

GENITOURINARY

- 1. () Bedwetting
 - 2. () Blood/Pus In Urine
 - 3. () Unusual Discharge
 - 4. () Sores On/Near Genitalia
 - 5. () Excessive Urination
 - 6. () Diminished Urination
 - 7. () Loss of Bladder Control
 - 8. () Painful Urination
 - 9. () Kidneys Ache
- Any other genitourinary problems

CARDIOVASCULAR

- 1. () High Blood Pressure
 - 2. () Irregular Heartbeat
 - 3. () Cold Hands Or Feet
 - 4. () Blood Clots
 - 5. () Low Blood Pressure
 - 6. () Dizziness
 - 7. () Swelling Of Hands
 - 8. () Phlebitis
 - 9. () Chest Pain
 - 10. () Fainting
 - 11. () Swelling Of Feet
 - 12. () Difficulty In Breathing
- Any other heart or blood vessel problems? _____

NEUROPSYCHOLOGICAL

- 1. () Seizures
- 2. () Areas Of Numbness
- 3. () Concussion
- 4. () Bad Temper
- 5. () Dizziness
- 6. () Lack Of Coordination
- 7. () Depression
- 8. () Easily Susceptible To Stress
- 9. () Loss Of Balance
- 10. () Poor Memory
- 11. () Anxiety
- 12. () Suicidal
- 13. () Uncomfortable being touched
- 14. () History of abuse
- 14. Have you ever been treated for emotional problems? _____

NMS

- 1. () Eyes Sensitive To Light
- 2. () Painful Or Stiff Neck
- 3. () Grinding Sounds In Neck
- 4. () Painful Or Clicking Jaw
- 5. () Pain Between Shoulder Blades
- 6. () Muscle Tension
- 7. () Muscle Cramp or Spasms
- 8. () Muscle Weakness
- 9. () Swollen/Stiff Joints
- 10. () Painful Joints
- 11. () Normal Range Of Motion Limited Or Painful
- 12. () Bursitis
- 13. () Feels Like Arthritis
- 14. () Cold Hands Or Feet
- 15. () Loss Of Strength/Grip
- 16. () Numbness In Limbs
- 17. () Pinched Nerve
- 18. () Sciatica
- 19. () Pain Shoots Down Leg
- 20. () Slipped Disc
- 21. () Sensation Of Pins And Needles Or Tingling
- 22. () Check area in which You experience pain.
 - () Foot () Mid Back
 - () Ankle () Neck
 - () Knee () Hand
 - () Leg () Wrist
 - () Hip Joint () Elbow
 - () Buttocks () Arm
 - () Low Back () Shoulder
 - () Other _____
- 23. () The pain gets worse when I:
 - () Sit () Cough
 - () Bend () Lay Down
 - () Stand () Work
 - () Stoop () Lift
 - () Walk () _____

HABITS

- 1. () Antacids
- 2. () Aspirin
- 3. () Laxatives
- 4. () Narcotics
- 5. () Tranquilizers
- 6. () Barbiturates
- 7. () Stimulants
- 8. () Painkiller
- 9. () Patent Medicines
- 10. () Muscle Relaxants
- 11. Average # of hours sleep per night _____
- 12. Alcohol: # of drinks per week _____
- 13. Tobacco: # of Cigarettes/day _____
- 14. Coffee: # of cups/day _____
- 15. Soft drinks: # of cans/day _____
- 16. OPTIONAL: Please list any "Recreational: drugs you have taken in the past, I.E., LSD, cocaine, marijuana, etc.

- 17. Please list any nutritional supplements you are currently taking

- 18. Exercise: _____ times per week
Describe: _____

- 19. Diet:
My diet is: _____
Typical American ___ Vegetarian ___
Restricted intake of (e.g. salt, sugar, dairy) _____

- Zone Diet ___ Atkins ___ Weight Watchers ___ Macrobiotic ___
Other _____

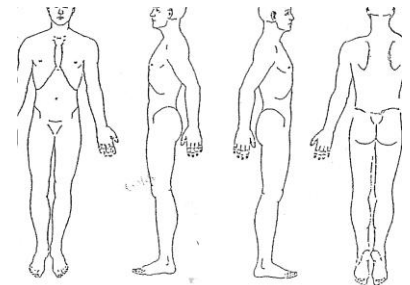
- 20. Eating habits:
Skip breakfast ___ 2 Meals/day ___
One meal/day ___ 3 Meals/day ___
Small frequent meals ___ Food rotation ___
Eat on the run ___ Eat constantly ___

- 21. Food Frequency:
Servings per day:
Fruits(citrus, melons etc.) _____
Dark green or yellow/orange vegetables _____
Grains(unprocessed) _____
Beans, peas, legumes _____
Dairy, eggs _____
Meat, poultry, fish _____

COMMENTS

Please tell us any other information you would like to discuss:

Shade areas of pain:



DOCTOR'S USE:

