Patient Name:_____ Date:_____

Does you pain ever wake you from a sound sleep?	Yes _____	No _____
Do you have vertigo (dizziness)?	Yes _____	No _____
Do you pass out easily (faint or loss of consciousness)?	Yes _____	No _____
Do you have double vision or have you lost sight in one eye?	Yes _____	No _____
Do you have any slurred speech or difficulty with speech?	Yes _____	No _____
Do you have indigestion or difficulty swallowing?	Yes _____	No _____
Do you have any difficulty walking, with coordination or falling to one side?	Yes _____	No _____
Do you have nausea or vomiting?	Yes _____	No _____
Do you have numbness on one side of your face or body?	Yes _____	No _____
Do you have any visual disturbances or rapid eye movement?	Yes _____	No _____
Do you have or have you ever had difficulty in arranging words properly?	Yes _____	No _____
Do you have a headache or head pain that is unlike any you have had before?	Yes _____	No _____
Do you have headaches for hours or days?	Yes _____	No _____
Do you have a history of stroke in your family?	Yes _____	No _____
Do you have chest pain?	Yes _____	No _____
Are you left-handed?	Yes _____	No _____
Do you have any change in bowel or bladder habits?	Yes _____	No _____
Have you had any loss of bladder or bowel control?	Yes _____	No _____
Are you losing weight now without trying?	Yes _____	No _____
Are you coughing up blood or noticing it in your stools or urine?	Yes _____	No _____
Do you have a sore that does not heal?	Yes _____	No _____
Do you have any unusual bleeding or discharge?	Yes _____	No _____
Do you have any thickening in your breasts or elsewhere?	Yes _____	No _____
Do you have a change in any wart or mole?	Yes _____	No _____
Do you have a nagging cough or hoarseness?	Yes _____	No _____
Do you have night sweats?	Yes _____	No _____
Do you have pain in neck, jaw or face?	Yes _____	No _____
Do you have a drooping eyelid or change in your pupils?	Yes _____	No _____
Do you have any ringing in your ears?	Yes _____	No _____
Do you use birth control pills, patches, rings, etc?	Yes _____	No _____

Please list prescription medications you are taking if any.

[ ] High blood pressure medication _____

[ ] Blood thinners _____

[ ] Steroid medications or shots_____

[ ] Herbs, vitamins, or over the counter products

[ ] Others:

Please list all surgeries (including the year) and hospitalizations you have experienced.

Patient Name:_____ Date:_____

Do you have any artificial joints, pins, plates or implants? Yes _____ No____

Have you ever broken any bones in your body? Yes _____ No ____

Date of your last physical exam with a physician _____
Date of your last dental check up _____
Date of your last gynecological/proctology exam_____
Could you be pregnant? Yes_____ No_____ Date of last menses_____
Date of your last mammogram_____ colonoscopy _____
Are you seeing any other doctor now for any reason? Yes ____ No ____
Please discuss:

_____

TOBACCO Yes or No _____ ALCOHOL Yes or No _____
CAFFEINE Yes or No _____ RECREATIONAL DRUGS Yes or No _____
SEAT BELT USE Yes or No DOMESTIC VIOLENCE Yes or No

_____

Do/Did you mother, father, siblings, or grandparents have any of the following?
Put an **X** for yourself**, M** for mother, **F** for father, **B** for brother, **S** for sister, and **G** for grandparent.

_____High Blood Pressure
_____Heart Attack
_____Emphysema
_____Seizure-Convulsions
_____Diabetes
_____Asthma
_____Arthritis-Rheumatism
_____Stroke
_____Thyroid Disease
_____Circulation Problems
_____Cancer

Please circle any condition below that you have.
Problems with: skin/hair/nails mouth/teeth nose/throat/sinuses ear eye

chest/lung/breathing heart/blood vessels digestion genitals

bones/ligaments joints muscles/tendons glands/hormones

kidney/bladder immune system nervous system diseases/mental health

Please list below any other diseases, conditions, experiences, details, or information that we have not already requested that would help us to give you the best care possible.

DATE: _____ SIGNATURE_____

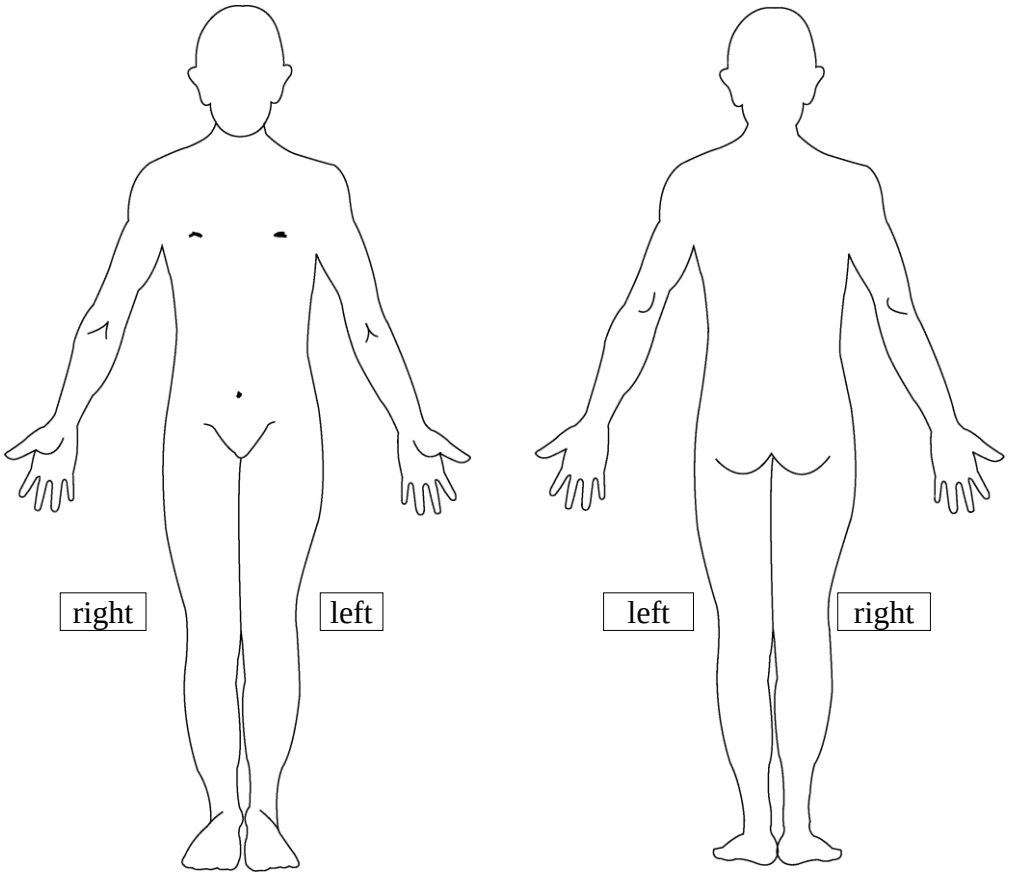
Patient Name:_____ Date:_____

Mark the areas on this body where you feel the described sensations. Use the appropriate symbols.
Mark areas of radiation. Include all affected areas.

Numbness	Pins & Needles	Burning	Aching	Stabbing
- - - - -	00000	xxxxx	*****	/ / / / /

Please mark on the pain scale, from zero to ten, the pain you feel with this condition **now.**
0 being no pain, 10 being the worst pain you have felt with this condition.

Pain Chart



Neck-Shoulder-Arm-Pain
On a scale of zero to 10, I rate my discomfort as follows:
(_____)
0 10
no pain severe pain

Mid Back Pain
On a scale of zero to 10, I rate my discomfort as follows:
(_____)
0 10
no pain severe pain

Low Back and Leg Pain
On a scale of zero to 10, I rate my discomfort as follows:
(_____)
0 10
no pain severe pain

I request services from T.A. Huffman, Inc, dba Huffman Chiropractic and I am legally able to sign for my own care. All of the information supplied by me on these forms is true and accurate to the best of my knowledge. I have not intentionally omitted any information.

I acknowledge that I have read, or had the opportunity to read, a copy of Huffman Chiropractic's Notice of Privacy Practices.

I have also read and freely signed a copy of the Huffman Chiropractic Financial Agreement. I understand that I am **PERSONALLY RESPONSIBLE FOR PAYMENT OF ALL FEES** associated with my care and that Huffman Chiropractic will collect all fees DIRECTLY FROM ME in the form of cash, check, or money order. Huffman Chiropractic does not accept credit or debit cards.

Signature _____ Date _____