# Pruitt Chiropractic Clinic

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**Patient**_____ #_____

**CHECK ANY OF THE FOLLOWING THAT YOU HAVE HAD IN THE PAST…**

| | | | | |
|---|---|---|---|---|
| [] Heart Attack | [] Cancer | [] Diabetes | [] Epilepsy | [] Rheumatic Fever |
| [] Polio | [] Chicken Pox | [] Measles | [] Mumps | [] Whooping Cough |
| [] Scarlet Fever | [] Alcoholism | [] Depression | [] Drug Problem | [] Venereal Disease |

**CHECK ANY OF THE FOLLOWING CONDITIONS THAT YOU HAVE HAD RECENTLY…**

**General Symptoms:**

| | | | | |
|---|---|---|---|---|
| [] Headaches | [] Colds/Fevers | [] Influenza | [] Fainting | [] Dizziness |
| [] Nervousness | [] Convulsions | [] Insomnia | [] Fatigue | [] Loss of Taste |
| [] Loss of Balance | [] Weight Gain | [] Weight Loss | [] Drug Allergies | [] Respiratory Allergies |

**Cardiovascular:**

| | | | |
|---|---|---|---|
| [] Arrhythmia | [] Chest Pain | [] High Blood Pressure | [] Low Blood Pressure |
| [] Poor Circulation | [] Alzheimer's Disease | [] Cold Hands/Feet | [] Varicose Veins |
| [] Swollen Ankles | [] Previous Stroke | [] Anemia | [] High Cholesterol |

**Respiratory:**

| | | | |
|---|---|---|---|
| [] Bronchitis | [] Asthma | [] Chronic Cough | [] Breathing Difficulty |
| [] Spitting Up Blood | [] Pleurisy | [] Pneumonia | [] Tuberculosis |

**Eyes/Ears/Nose/Throat:**

| | | | |
|---|---|---|---|
| [] Poor Vision | [] Eye Pain/Infection | [] Nose Bleeds | [] Sinus Problems |
| [] Post Nasal Drip | [] Sore Throats | [] Hay Fever | [] Ear Ache/Infection |
| [] Hearing Loss | [] Ringing in Ears | [] Asthma | [] Thyroid Problem |

**Gastro-Intestinal:**

| | | | |
|---|---|---|---|
| [] Poor Appetite | [] Abdominal Pain | [] Nausea | [] Vomiting |
| [] Ulcers | [] Reflux/Heartburn | [] Intestinal Gas | [] Indigestion |
| [] Colitis | [] Liver Problem | [] Hemorrhoids | [] Blood in stool |
| [] Appendicitis | [] Constipation | [] Diarrhea | [] Gall Bladder Problem |

**Genito-Urinary:**

| | | | |
|---|---|---|---|
| [] Urinary Frequency | [] Painful Urination | [] Bedwetting | [] Kidney Infections |
| [] Incontinence | [] Blood/Pus in Urine | [] Prostate Problem | [] Bladder Infections |

**Muscle & Joint:**

| | | | |
|---|---|---|---|
| [] Neck Pain/Stiffness | [] Shoulder Pain | [] Arm Pain | [] Mid-Back Pain |
| [] Lower Back Pain | [] Disc Problem | [] Leg Pain | [] Numbness/Tingling |
| [] Painful Tailbone | [] Spinal Curvature | [] Foot Problem | [] Arthritis |

**Skin:**

| | | | |
|---|---|---|---|
| [] Eruptions | [] Itching/Dryness | [] Eczema | [] Bruises Easily |
| [] Boils | [] Hives | [] Skin Allergies | [] Sensitive Skin |

**PLEASE READ THE FOLLOWING AND SIGN AT THE SPACE PROVIDED**

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I also understand that the doctor's office will assist me in collecting from the insurance company, except when the doctor accepts assignment, and that any amount authorized to be paid directly to the doctor will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that any fees for professional services rendered me will be due and payable immediately if I suspend or terminate my care. My signature constitutes permission to treat me or my family member.

**Patient (or Guardian) Signature** _____ **Date** _____