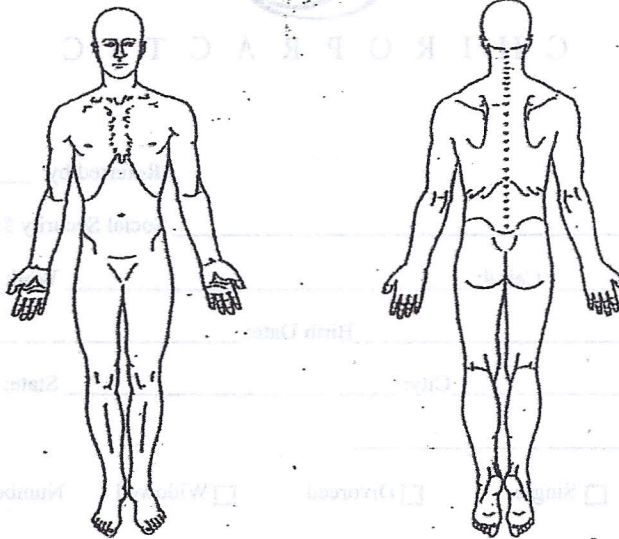


If you are in pain, please mark the exact location of your pain on the diagram below. Also describe the type and frequency of your pain, as well as any activity, which brings on or aggravates the pain. For example, describe as dull, sharp, constant, off & on, when standing, when sitting, etc.



Check appropriate squares (x) past or (✓) present condition:

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> Headaches           | <input type="checkbox"/> Mental, emotional conditions | <input type="checkbox"/> Bursitis               | <input type="checkbox"/> Kidney troubles         |
| <input type="checkbox"/> Nervousness         | <input type="checkbox"/> Convulsions                  | <input type="checkbox"/> Thyroid condition      | <input type="checkbox"/> Constipation            |
| <input type="checkbox"/> Insomnia            | <input type="checkbox"/> Acne                         | <input type="checkbox"/> Asthma                 | <input type="checkbox"/> Colitis                 |
| <input type="checkbox"/> Head colds          | <input type="checkbox"/> Eczema                       | <input type="checkbox"/> Cough                  | <input type="checkbox"/> Dysentery               |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Hay Fever                    | <input type="checkbox"/> Difficult breathing    | <input type="checkbox"/> Diarrhea                |
| <input type="checkbox"/> Migraines           | <input type="checkbox"/> Adenoids                     | <input type="checkbox"/> Shortness of breath    | <input type="checkbox"/> Ruptures                |
| <input type="checkbox"/> Nervous breakdown   | <input type="checkbox"/> Hearing loss                 | <input type="checkbox"/> Heart condition        | <input type="checkbox"/> Hernias                 |
| <input type="checkbox"/> Chronic tiredness   | <input type="checkbox"/> Ringing ear                  | <input type="checkbox"/> Bronchitis             | <input type="checkbox"/> Cramps                  |
| <input type="checkbox"/> Dizziness           | <input type="checkbox"/> Laryngitis                   | <input type="checkbox"/> Pleurisy               | <input type="checkbox"/> Varicose veins          |
| <input type="checkbox"/> Sinus troubles      | <input type="checkbox"/> Hoarseness                   | <input type="checkbox"/> Pneumonia              | <input type="checkbox"/> Bladder troubles        |
| <input type="checkbox"/> Eye problems        | <input type="checkbox"/> Sore throat                  | <input type="checkbox"/> Congestion             | <input type="checkbox"/> Menstrual problems      |
| <input type="checkbox"/> Excessive sweating  | <input type="checkbox"/> Tonsillitis                  | <input type="checkbox"/> Influenza              | <input type="checkbox"/> Miscarriages            |
| <input type="checkbox"/> Ear ache            | <input type="checkbox"/> Croup                        | <input type="checkbox"/> Gall bladder condition | <input type="checkbox"/> Bed wetting             |
| <input type="checkbox"/> Ulcers              | <input type="checkbox"/> Poor circulation             | <input type="checkbox"/> Jaundice               | <input type="checkbox"/> Impotency               |
| <input type="checkbox"/> Stomach troubles    | <input type="checkbox"/> Swollen ankles               | <input type="checkbox"/> Shingles               | <input type="checkbox"/> Change of life symptoms |
| <input type="checkbox"/> Indigestion         | <input type="checkbox"/> Cold feet                    | <input type="checkbox"/> Liver condition        | <input type="checkbox"/> Knee pain               |
| <input type="checkbox"/> Heartburn           | <input type="checkbox"/> Weakness in legs             | <input type="checkbox"/> Fever                  | <input type="checkbox"/> Sciatica                |
| <input type="checkbox"/> Gastritis           | <input type="checkbox"/> Leg cramps                   | <input type="checkbox"/> Low blood pressure     | <input type="checkbox"/> Difficult urination     |
| <input type="checkbox"/> Lowered resistance  | <input type="checkbox"/> Hemorrhoids (piles)          | <input type="checkbox"/> Arthritis              | <input type="checkbox"/> Painful urination       |
| <input type="checkbox"/> Diabetes            |   |   | <input type="checkbox"/> Frequent urination      |

**PATIENT AUTHORIZATION REGARDING OUR OPEN DOOR ADJUSTING ENVIRONMENT, SIGN-IN SHEETS, TRAVEL CARD USE AND PATIENT RECORD OF DISCLOSURES.**

Our office uses sign in sheets, travel cards and provides care in an "open door" adjusting environment. Adjustments are done in an open adjusting area. As a result patients are in sight of each other and some ongoing routine details of care may be in earshot of other patients and staff. This environment is used for ongoing care and is not the environment for taking patient's histories, performing examinations or presenting report of findings. These procedures are done in a private, confidential setting. If you choose not to be adjusted in an open-door adjusting environment, other arrangements will be made for you. Your signature below indicates your authorization for this activity. In addition your signature below authorizes us to contact you at all the phone numbers/addresses you list on this intake form. If you do not wish to be contacted at any listed numbers/addresses, please let us know.

Patient's Signature \_\_\_\_\_

Date \_\_\_\_\_

Privacy Policy Received

Patient's Signature \_\_\_\_\_

Date \_\_\_\_\_