Integrative Health Lewiston Family Chiropractic, LLC

Tobacco:	□ Yes	\square No	□ Quit	☐ Smokeless	Packs per day:# of yrs:
Alcohol Use:			☐ Daily How much per		week?
Recreational Drugs:		\square No	☐ Yes ☐ Amphetamine		es Other:
Caffeine:		\square No	How much per day?		
Family History:	Father	☐ Deceased	\Box Living	Age:	Medical Problems:
	Mother	\Box Deceased	☐ Living	Age:	Medical Problems:
	Siblings	\Box Deceased	\square Living	Age:	Medical Problems:
	Spouse	☐ Deceased		Age:	Medical Problems:
Please check if you <u>have</u> or <u>had</u> any of the following:					
MUSCLES / SKELETAL			EUROLOGICAL / MIGRAINES		EYES / VISION
☐ Arthritis			Severe/frequent headaches		☐ Eye pain or redness
□ Polio			Dizziness/fainting spells		□ Loss or change of vision
☐ Joint infection, pain, swelling			☐ Seizures/convulsions		☐ Double or blurred vision
☐ Loss of motion in joints			☐ Shaking/twitching limbs		☐ Corrective glasses/contacts
☐ Bone fractures			☐ Paralysis of limbs		
☐ Spine abnormality					EMOTIONAL
☐ Brittle or soft bones			NOGE / TWO A T		☐ Emotional illness
☐ Bursitis/tendonitis			NOSE / THROAT		□ Depression
			☐ Hoarseness		□ Anxiety
HEART / CARDIOVASCULAR			☐ Blocked nasal passages		☐ Feelings of worthlessness
☐ Chest pain			Nose bleeds		☐ Physical abuse
☐ Abnormal heartbeat			Difficulty swallowing		☐ Frequent nightmares
☐ High/low blood pressure			Allergies		☐ Hysterical attacks
☐ Fingers/toes sensitive to cold		a			☐ Difficulty sleeping
☐ Heart disease ☐ Heart murmur			URINARY		
			Bloody urine		MALE
☐ Rheumatic fever			Painful/difficult urination		☐ Abnormality of testicles
BREATHING / RESPIRATORY			Kidney/urine problems		□ Varicocele
☐ Breathing problems			Flank pain		☐ Difficulty in sexual function
☐ Excessive cough			•		☐ Genital pain
□ Night sweats					☐ Plastic Surgery
☐ Allergy/cold symptoms			TOMACH / IN		
□ Pneumonia			Frequent nausea/	vomiting	
□ Emphysema			☐ Bloody vomitus		FEMALE
□ Asthma			Stomach, abdominal, bowel pain		☐ Breast pain
\Box TB			Recurring diarrhea		☐ Breast implants/reduction
			☐ Blood in stools		☐ Uterine fibroids/tumors
EARS / HEARING			Hemorrhoids		☐ Painful menses/excessive bleeding
☐ Loss of hearing			Frequent/severe constipation		☐ Genital pain
☐ Buzzing or noise in ear			Diabetes, gallbladder disease Hernia		□ Difficulty in sexual function□ Plastic Surgery
Patient Signature:					Date: