WOODBURY CHIROPRACTIC
& WELLNESS CENTER

**If you have any difficulty with the following, please indicate with an X.**

- ✯ Headaches
- ✯ Shooting head pains
- ✯ Sinus trouble
- ✯ Loss of smell
- ✯ Hay fever
- ✯ Asthma
- ✯ Loss of taste
- ✯ Tightness of throat
- ✯ Inflammation of throat
- ✯ Thyroid trouble
- ✯ Face flushed
- ✯ Twitching of face
- ✯ Loss of memory
- ✯ Fatigue
- ✯ Depression
- ✯ Head feels too heavy
- ✯ Dizziness
- ✯ Fainting
- ✯ Loss of balance
- ✯ Ringing in ears
- ✯ Wear glasses
- ✯ Lights bother eyes
- ✯ Muscle spasms in neck
- ✯ Grating in neck
- ✯ Tightness in shoulders and arms
- ✯ Neuritis in shoulders and arms
- ✯ Pins and needles in arms and hands
- ✯ Cold hands
- ✯ Chest pains
- ✯ Shortness of breath
- ✯ T.B.
- ✯ Heart Pain
- ✯ Heart palpitations
- ✯ Heart attacks
- ✯ High blood pressure
- ✯ Low blood pressure
- ✯ Anemia
- ✯ Rheumatic fever
- ✯ Nervous stomach
- ✯ Stomach trouble
- ✯ Ulcers
- ✯ Nerves and nervousness
- ✯ Inner tension
- ✯ Irritability
- ✯ Cold Sweats
- ✯ Liver trouble
- ✯ Gall bladder trouble
- ✯ Indigestion
- ✯ Intestinal Gas
- ✯ Constipation
- ✯ Kidney Trouble
- ✯ Bladder trouble
- ✯ Menstrual cramps
- ✯ Menstrual Irregularity
- ✯ Diabetes
- ✯ Cancer
- ✯ Sleeping problems
- ✯ Painful joints
- ✯ Swollen joints
- ✯ Arthritis
- ✯ Slipped disc
- ✯ Pinched nerves
- ✯ Pins + needles in legs
- ✯ Swollen ankles
- ✯ Cold feet
- ✯ Pain in legs & feet

Additional Info:

_____

_____

Date_____

Name_____Age_____Birthdate_____
Name of Spouse_____Children_____
Address_____City/State/Zip_____
Home#_____Work#_____Cell#_____
Occupation/Hobbies_____
Employer_____Email_____
How did you hear about the office? Please tell us who referred you so we can thank them!_____

Describe your present symptoms in full:_____
_____
Date your present symptoms started:_____
Have you had a similar condition before?_____
If so, when?_____

Did you receive treatment?_____
Who treated you?_____

Have you had Chiropractic care before?_____
If so, when?_____
Are you taking any medications?_____
List any and all surgeries:_____
List all previous accidents and dates:_____

*Please complete the reverse side of this form*

*Patient Signature*_____

I have read and agree to the HIPAA Compliance Statement for Woodbury Chiropractic & Wellness Center

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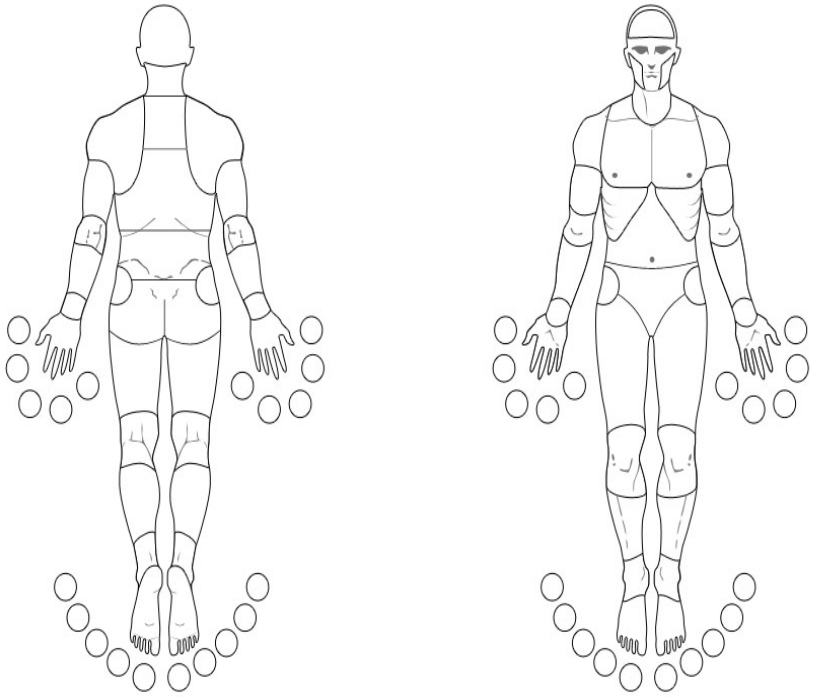
Please indicate the current complaints you are experiencing by marking the areas on the image below and providing details using the sections that follow.

* =Pain  # =Numbness  SS = Tingling  B =Burning  // = Stiffness

Remember = Please indicate ALL areas of discomfort, not only the most painful areas.



On scale of 1 to 10, please rate your overall symptoms today and over the past week

0 = feeling the Best  10 = Worst Feeling

Today:_____  Past Week:_____

Patient/Parent or Guardian Signature: _____ Date: _____