

Comprehensive Chiropractic

113 W. 5th St., Eureka MO 63025 (636) 938-9310

1750 Gravois Rd., High Ridge MO 63049 (636) 677-4345

CLINICAL RECORD

Name	Address	Date		
Phone - -	Date of Birth	Age	Sex	F M
Occupation	S / M / D / W	# of Children		
Referred by				

Please circle ALL of the following symptoms which you have now and underline all symptoms you have had previously. We want all of the facts about your health before we accept your case. Your health report is confidential and is treated as such by our staff.

GENERAL SYMPTOMS

Headache
Fever
Chills
Sweats
Fainting
Dizziness
Convulsions
Loss of Sleep
Numbness or Pain in Arms/Hands/Legs
Allergy
Wheezing
Neuralgia

EARS/EYES/NOSE/THROAT

Failing Vision
Near Sightedness
Far Sightedness
Crossed Eyes
Eye Pain
Deafness
Earache
Ear Noises
Ear Discharge
Nose Bleed
Nasal Obstruction
Sore Throat
Hoarseness
Hay Fever
Asthma
Dental Decay
Gum Trouble
Frequent Colds
Enlarged Thyroid
Tonsillitis
Sinus Infection
Nasal Drainage
Enlarged Glands

SKIN

Skin Eruptions
Itching
Bruises Easily
Dryness
Boils
Varicose Veins
Sensitive Skin
Hives or Allergy

RESPIRATORY

Chronic Cough
Spitting up Phlegm
Spitting up Blood
Chest Pain
Difficulty Breathing

CARDIO-VASCULAR

Rapid Beating Heart
Slow Beating Heart
High Blood Pressure
Low Blood Pressure
Pain over Heart
Previous Heart Stroke
Hardening of Arteries
Swelling of Ankles
Poor Circulation
Paralytic Stroke

MUSCLE & JOINT SYMPTOMS

Stiff Neck
Back Ache
Swollen Joints
Tremors
Painful Tail Bone
Foot Trouble
Pain between Shoulders
Hernia
Spinal Curvature
Faulty Posture

GENITOURINARY

Frequent Urination
Painful Urination
Blood in Urine
Pus in Urine
Kidney Infection or Stones
Bed Wetting
Inability to Control Urine
Prostate Trouble

GASTROINTESTINAL SYMPT.

Poor Appetite
Difficult Digestion
Excessive Hunger
Belching or Gas
Nausea
Vomiting
Vomiting of Blood
Pain over Stomach
Distention of Abdomen
Constipation
Diarrhea
Colon Trouble
Hemorrhoids (Piles)
Intestinal Worms
Liver Trouble
Gall Bladder Trouble
Jaundice
Colitis

WOMEN ONLY

Painful Menstrual Cycle
Excessive Flow
Hot Flashes
Irregular Cycle
Cramps or Backache
Previous Miscarriage
Vaginal Discharge
Congested Breast
Lumps in Breast
Menopausal Symptoms

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CURRENT HEALTH CONDITIONS

Name: _____
(Please Print)

Other doctors seen for this condition: YES / NO

Who:

Type of treatment:

Results:

When did this condition begin:

Has this condition occurred before: YES / NO

Is condition: Job Related / Auto Related / Home Injury / Fall / Other:

(Circle One)

Date of accident:

Time of accident:

am / pm

Have you made a report of your accident to your employer? YES / NO

Drugs you are currently taking: Nerve Pills / Pain Killers or Muscle Relaxants / Blood Pressure / Insulin

(Circle all that apply) Other(s):

Do you wear a shoe lift? YES / NO

Do you suffer from ANY condition other than which you are consulting us? YES / NO

Please describe:

PAST HEALTH CONDITIONS

Please circle or describe:

Major Surgery/Operations	Appendectomy / Tonsillectomy / Gall Bladder / Hernia / Back Surgery / Broken Bones / Other
Major accident(s) or fall(s):	
Hospitalization (Other than above):	
Previous Chiropractic Care:	None
OR	Doctor's Name:
	Approx. date of last visit:

FAMILY HISTORY

RELATION	NAME	AGE	PRESENT SYMPTOMS	PREVIOUS SERIOUS ILLNESS
FATHER				
MOTHER				
BROTHER(S)				
SISTER(S)				
CHILD(REN)				

Name & # of Emergency Contact:

Relation:

Have you ever been to any major medical clinics? YES / NO

REMARKS: