

**HEALTH REVIEW**

**SKIN, HAIR and NAILS:**

- ( )eczema ( )rough, scaly skin ( )dry/itchy skin/scalp ( )paper thin nails ( )bruise easily
( )psoriasis ( )yellow/pale skin ( )oily skin/scalp ( )nail biting ( )alopecia/baldness

**EYES and EARS:**

- ( )eyes fatigue easily ( )excessive tearing ( )lack of tearing ( )loss of hearing ( )discharge from ears
( )unusual sensitivity ( )pain in eyeball ( )excessive eye itching ( )pain in ears ( )ringing in ears

**NOSE, NASOPHARYNX, SINUSES, MOUTH and THROAT:**

- ( )nasal discharge ( )pain in mouth ( )dentures ( )pressure under eyes ( )frequent colds
( )nose bleeds ( )pain in throat ( )abscessed teeth ( )pressure over eyes ( )nasal allergies
( )bleeding gums ( )difficulty swallowing ( )cavities ( )sinusitis

**RESPIRATORY:**

- ( )shortness of breath ( )dry cough ( )productive cough ( )wheezing ( allergies\_\_\_\_\_

**GASTROINTESTINAL:**

- ( )poor appetite ( )indigestion ( )nausea and vomiting ( )abdominal pain
( )change in bowel habits ( )diarrhea ( )constipation ( )hemorrhoids

**GENITOURINARY:**

- Urination is.....( )frequent ( )normal ( )infrequent
The amount is.....( )high ( )normal ( )low
( )can disturb sleep ( )intense need to urinate ( )difficulty starting flow ( )pain on urination
( )dribbling ( )blood in urine ( )cloudy urine ( )lack of bladder control

**VENEREAL DISEASE**

- ( )syphilis ( )gonorrhea ( )herpes ( )other

**SOCIAL HISTORY:**

- Diet is.....( )balanced ( )unbalanced Rest is.....( )sufficient ( )not sufficient
Recreation.....( )sufficient ( )not sufficient
My job is.....( )pleasing ( )okay ( )miserable
My family stress is.....( )severe ( )moderate ( )minimal
My job stress is.....( )severe ( )moderate ( )minimal

- I regularly use.....( )tobacco ( )tea I regularly drink.....( )coffee ( )alcohol
I often experience.....( )nervousness ( )irritability ( )fatigue ( )depression ( )lethargy
I have cravings for.....( )sweets ( )salty foods

**WOMEN ONLY:**

- ( )painful period ( )vaginal discharge ( )abnormal PMS ( )irregular periods ( )lumps in breast
Number of Pregnancies\_\_\_\_\_ Number of Deliveries\_\_\_\_\_

**CONSENT FOR TREATMENT AND AUTHORIZATION TO PERFORM X-RAYS**

I am aware that diagnostic x-rays may be needed for a complete analysis of my present condition. If Dr. Morton advises me that x-rays are needed, I authorize Primary Care Chiropractic to perform such radiographic examination necessary to properly diagnose my present problem.

I also authorize Dr. Morton to administer whatever treatment is deemed necessary to treat my present condition.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

**WOMEN ONLY**

To the best of my knowledge, I am NOT pregnant and the above named Doctor has my permission to x-ray me for diagnostic interpretation.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_