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 I regularly drink…………….( )coffee ( )alcohol ( )tea

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:____