

# Symptom History

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY/STATE/ZIP: \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_ SEX: \_\_\_\_\_ AGE: \_\_\_\_\_

## CIRCLE ANY OF THE FOLLOWING MEDICATIONS YOU ARE TAKING:

- |                          |                                |                           |                               |
|--------------------------|--------------------------------|---------------------------|-------------------------------|
| *Antacids                | *Chemotherapy                  | *Hormones                 | *Recreational Drugs (Specify) |
| *Antibiotics/Antifungals | *Cortisone Anti-inflammatories | *Laxatives                | *Ulcer Medications            |
| *Antidepressants         | *Diuretics                     | *Lithium                  | *Aspirin or Tylenol           |
| *Antidiabetic/Insulin    | *Heart Medications             | *Oral Contraceptives      | *Other (Specify)              |
| *High Blood Pressure     | *Thyroid                       | *Relaxants/Sleeping pills |                               |

## CIRCLE IF YOU EAT, DRINK, OR USE:

- |                                      |                                 |                            |
|--------------------------------------|---------------------------------|----------------------------|
| *Alcohol                             | *Distilled Water                | *Milk Products             |
| *Candy or Refined Sugar              | *Fluoridated/Chlorinated Water  | *Refined (white) Flour     |
| *Carbonated Beverages                | *Frequent Fast Food Restaurants | *Salt Food Without Tasting |
| *Chemical Exposure                   | *Luncheon Meat                  | *Under Excessive Stress    |
| *Cigarettes or Exposure to           | *Margarine                      | *Sweeteners                |
| *Coffee                              | *Tea                            | *Tobacco (chewing)         |
| *Vitamins & Minerals (Specify Below) |                                 |                            |

**DIRECTIONS:** Please read each description and fill in the number that best describes the frequency of your symptoms within the past year. If you do not understand a symptom, put a "?" before the symptom's number. When done add each Section and put the total in the Total box.

**KEY:** Leave Blank = Never

- 1 = Mild (Occurs once a month or less)
- 2 = Moderate (Occurs several times monthly)
- 3 = Severe (Aware of it almost constantly)

## IMPORTANT

Please list your five major health concerns in order of importance:

Specify any drugs, vitamins and minerals not mentioned above:

1. \_\_\_\_\_

1. \_\_\_\_\_

2. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

4. \_\_\_\_\_

5. \_\_\_\_\_

5. \_\_\_\_\_

- A.01. History of constipation?
- A.02. Bad breath/halitosis?
- A.03. Loss of taste for meat?
- A.04. Belching shortly after meals?
- A.05. Bloating or gas shortly after meals?

Total Section A

- B.01. Burning or gnawing stomach pain?
- B.02. Heartburn or indigestion after meals?
- B.03. Stomach pain from stress and/or spicy foods?
- B.04. Told you have Ulcers?
- B.05. Use antacids or aspirin?
- B.06. Use milk or carbonated drinks to relieve stomach pain?

Total Section B

- C.01. Remnants of food or fibers in stools?
- C.02. Nausea or diarrhea?
- C.03. Mucus in stools?
- C.04. Pass gas frequently?

Total Section C

- D.01. Pain or discomfort in abdomen area?
- D.02. Have allergies?
- D.03. Self or Family history of autoimmune disease?
- D.04. Drink alcohol?
- D.05. Drink milk or eat dairy products?
- D.06. Often have constipation or diarrhea?
- D.07. Frequently have gas?

Total Section D

- E.01. Coated or fuzzy debris on tongue?
- E.02. Bowel movements painful or difficult?
- E.03. Irritable bowel or colitis?
- E.04. Have bad breath?

Total Section E

- F.01. Burning or itching anus?
- F.02. Frequently get skin eruptions or bumps?
- F.03. History of yeast infections, antibiotic use?
- F.04. Use or have used estrogen compounds?
- F.05. Have intestinal pain for no apparent reason?
- F.06. Have diarrhea?
- F.07. Have allergies or sensitivities?
- F.08. Get sick often or stay sick?
- F.09. Feel tired all the time?

Total Section F

- G.01. Pain or discomfort on right side under ribcage?
- G.02. Blurred vision?
- G.03. Intolerance to greasy foods?
- G.04. Eat fast food?
- G.05. Tightness or pain between shoulder blades?
- G.06. Light-colored or foul smelling stools?
- G.07. Feel nauseous or queasy after eating fatty foods?
- G.08. Drink coffee?
- G.09. Dry skin, itchy or peeling feet?
- G.10. Retaining water?
- G.11. Gag easily?
- G.12. Sour or metallic taste in mouth?

Total Section G

- H.01. Feet burn?
- H.02. Noises in head or ringing in the ears?
- H.03. Strong light irritates eyes?
- H.04. Drink alcohol?
- H.05. Sensitive to fumes, smoke, smells, or chemicals?
- H.06. Thick stringy mucus or swollen lymph nodes?
- H.07. Have allergies?
- H.08. Eat luncheon meat?
- H.09. Bronzing of skin or brown spots?

Total Section H

- I.01. Head congestion or sinus fullness?
- I.02. Frequent sneezing?
- I.03. Eyes and nose watery, swollen or puffy?
- I.04. Nightmare-like dreams?
- I.05. Dark circles under eyes?
- I.06. Certain foods cause distress (dairy, corn, wheat)?
- I.07. Sensitive to fumes, smoke or chemicals?
- I.08. Thick mucus or swollen lymph nodes?
- I.09. Chronic sinus infections?

Total Section I

- J.01. Crave sweets or coffee in afternoon or mid-morning?
- J.02. Hungry between meals or excessive appetite?
- J.03. Irritable before meals or if meals delayed?
- J.04. Get shaky or light-headed if meals delayed?
- J.05. Wake in the night and can't go back to sleep?
- J.06. Problems with memory in mid-morning or after noon?
- J.07. Eat sweets, refined foods, or fast foods?

Total Section J

- K.01. Family history of diabetes?
- K.02. Excessive thirst?
- K.03. Excessive urination?
- K.04. Fasting glucose greater than 120 mg/dl?
- K.05. Overweight by 50 or more pounds?

Total Section K

- L.01. Difficulty maintaining chiropractic adjustments?
- L.02. Crave salt?
- L.03. Low blood pressure?
- L.04. Weakness after colds or slow recovery?
- L.05. Headaches in afternoon?
- L.06. Muscular or nervous exhaustion?
- L.07. Chronic fatigue or slow starter in the morning?
- L.08. Have allergies or sensitivities?

Total Section L

- M.01. Have anxiety?
- M.02. Problems sleeping or insomnia?
- M.03. Crave sweets or coffee in the afternoon or mid-morning?
- M.04. Get shaky or light-headed if meals delayed?
- M.05. Retain water?
- M.06. Are under a lot of stress?
- M.07. Feel tired or sleepy in afternoon?
- M.08. Eat refined flour products, sugar or drink coffee?

Total Section M

- N.01. Hair and skin dry but not coarse?
- N.02. Weight gain around hips and waist?
- N.03. Sex drive reduced or absent?
- N.04. Impotence or decrease in size of testes (males).
- N.05. Infertile or decrease in size of breasts (females).
- N.06. Abnormal thirst?
- N.07. Lack of menstruation (females)?

Total Section N

- O.01. Feel worse after chiropractic adjustment?
- O.02. Forgetful, mental sluggishness, or reduced initiative?
- O.03. Skin coarse and dry?
- O.04. Cold hands and feet?
- O.05. Frequent constipation?
- O.06. Headaches upon awakening?
- O.07. Gain weight easily?
- O.08. Cry easily, worse with change in season?
- O.09. Hair thin or falling out?
- O.10. Feel depressed?

Total Section O

Only Females Answer Section P

- P.01. Menstruates too frequently?
- P.02. Acne worse at menses?
- P.03. Scanty or missed menses?
- P.04. Painful or tender breasts?
- P.05. Have had hysterectomy?
- P.06. Mood changes or irritability before menses?
- P.07. Painful menses or cramping during menses?
- P.08. Menstruation excessive or prolonged?
- P.09. Menopausal depression?
- P.10. Have hot flashes?
- P.11. Depression before menses?

Total Section P

Only Males Answer Section Q

- Q.01. History of prostate problems?
- Q.02. Decreased size and force of urinary stream?
- Q.03. Reduced sex drive?
- Q.04. Dribbling after urination?
- Q.05. Frequent night urination?
- Q.06. Feeling of incomplete bowel evacuation?
- Q.07. Difficulty stopping urinary flow?
- Q.08. Leg nervousness at night?
- Q.09. Pain on side of legs or on inside of heels?

Total Section Q

- R.01. Chest pain or shortness of breath on exertion?
- R.02. Swollen ankles, worse at night?
- R.03. Personal or family history of cardiovascular disease?
- R.04. High cholesterol or triglycerides?
- R.05. Pain under sternum that radiates to the left shoulder?
- R.06. Air hunger, sigh frequently or labored breathing?
- R.07. Irregular heartbeat?
- R.08. Snores while sleeping?
- R.09. Pain, cramp or tired feeling in foot, calf and hip?

Total Section R

- S.01. Have bronchial asthma or bronchitis?
- S.02. Frequent lung congestion?
- S.03. Live or work around people who smoke?
- S.04. Recurrent sinus or upper-respiratory infections?
- S.05. Chronic cough?

Total Section S

- T.01. Recurrent bladder or kidney infections?
- T.02. Painful burning when passing urine?
- T.03. Cloudy, rose-colored, or strong-smelling urine?
- T.04. Difficulty urinating?
- T.05. Urinary leakage or bedwetting?
- T.06. Back pain in kidney area?
- T.07. History of kidney problems?
- T.08. Have skin eruptions such as psoriasis or eczema?

Total Section T

- U.01. Pain in neck or shoulders?
- U.02. Tightness in shoulder muscles?
- U.03. Muscle cramps or spasms?
- U.04. Muscles and joints sore all over?

Total Section U

- V.01. Joint pain in hands or fingers?
- V.02. Told you have arthritis?
- V.03. Joint stiffness?
- V.04. Told you have herniated or slipped disc?

Total Section V

- W.01. Bones are sore or pain in fingers?
- W.02. Cavities or dentures?
- W.03. Gums bleed easily?
- W.04. Have muscle cramps?
- W.05. Told you have bone loss or Osteoporosis?

Total Section W

- X.01. Uncoordinated or unsteady walk?
- X.02. Pins and needle burning sensation in hands or feet?
- X.03. Muscle weakness or reflex loss?
- X.04. Loss of sense of vibration in legs?
- X.05. Memory loss?
- X.06. Restless leg?
- X.07. Dizziness?
- X.08. Irritable or moody?

Total Section X

- Y.01. Chronic infections?
- Y.02. Wounds heal slowly?
- Y.03. Loss of sense of taste and smell?
- Y.04. Fatigued?
- Y.05. White spots under fingernails?

Total Section Y

- ZA.01. Night vision poor?
- ZA.02. Strong light irritates eyes?
- ZA.03. Noises in head or ringing in ears?

Total Section ZA

- ZB.01. Vulnerable to insect bites?
- ZB.02. Loss of muscle tone or heaviness in arms and legs?
- ZB.03. Worrier, feel insecure, or highly emotional?
- ZB.04. Slow pulse or irregular heartbeat?
- ZB.05. Poor appetite?

Total Section ZB

- ZC.01. Burning sensation in mouth?
- ZC.02. Cannot recall dreams?
- ZC.03. Numbness in hands and/or feet?
- ZC.04. Intolerance to MSG?

Total Section ZC

- ZD.01. Intolerance to sulfites (found in wine)?
- ZD.02. Sensitive to perfumes or smells?

Total Section ZD

- ZE.01. Frequently irritable?
- ZE.02. Easily startled or nervous?
- ZE.03. Muscle, leg, or toe cramping at rest?
- ZE.04. Body odor or foot odor?
- ZE.05. Crave chocolate?

Total Section ZE

- ZF.01. "Lump" in throat?
- ZF.02. Dry mouth, eyes or nose?
- ZF.03. Gag easily?

Total Section ZF

- ZG.01. Fatigued all the time?
- ZG.02. Nails weak or ridged?
- ZG.03. History of anemia?
- ZG.04. Hands and feet often cold?
- ZG.05. Crave ice?
- ZG.06. "Whites" of eyes are blue tinted?

Total Section ZG

- ZH.01. Gums bleed easily?
- ZH.02. Bruise easily?

Total Section ZH

- ZI.01. Poor wound healing?
- ZI.02. Dry skin?
- ZI.03. Vision blurred or impaired?
- ZI.04. Chronic infections?
- ZI.05. Frequent skin problems?

Total Section ZI