Integrative Health & Wellness
Lewiston Family Chiropractic

Tobacco: □ Yes □ No □ Quit □ Smokeless Packs per day: _____# of yrs: _____

Alcohol Use: □ None □ Occasional □ Daily How much per week? _____

Recreational Drugs: □ No □ Yes □ Amphetamines □ Other: _____

Caffeine: □ Yes □ No How much per day? _____

Family History:

Father	□ Deceased	□ Living	Age: _____	Medical Problems: _____
Mother	□ Deceased	□ Living	Age: _____	Medical Problems: _____
Siblings	□ Deceased	□ Living	Age: _____	Medical Problems: _____
Spouse	□ Deceased	□ Living	Age: _____	Medical Problems: _____

Please check if you <u>have</u> or <u>had</u> any of the following:

MUSCLES / SKELETAL
□ Arthritis
□ Polio
□ Joint infection, pain, swelling
□ Loss of motion in joints
□ Bone fractures
□ Spine abnormality
□ Brittle or soft bones
□ Bursitis/tendonitis

HEART / CARDIOVASCULAR
□ Chest pain
□ Abnormal heartbeat
□ High/low blood pressure
□ Fingers/toes sensitive to cold
□ Heart disease
□ Heart murmur
□ Rheumatic fever

BREATHING / RESPIRATORY
□ Breathing problems
□ Excessive cough
□ Night sweats
□ Allergy/cold symptoms
□ Pneumonia
□ Emphysema
□ Asthma
□ TB

EARS / HEARING
□ Loss of hearing
□ Buzzing or noise in ear

NEUROLOGICAL / MIGRAINES
□ Severe/frequent headaches
□ Dizziness/fainting spells
□ Seizures/convulsions
□ Shaking/twitching limbs
□ Paralysis of limbs

NOSE / THROAT
□ Hoarseness
□ Blocked nasal passages
□ Nose bleeds
□ Difficulty swallowing
□ Allergies

URINARY
□ Bloody urine
□ Painful/difficult urination
□ Kidney/urine problems
□ Flank pain

STOMACH / INTESTINES
□ Frequent nausea/ vomiting
□ Bloody vomitus
□ Stomach, abdominal, bowel pain
□ Recurring diarrhea
□ Blood in stools
□ Hemorrhoids
□ Frequent/severe constipation
□ Diabetes, gallbladder disease
□ Hernia

EYES / VISION
□ Eye pain or redness
□ Loss or change of vision
□ Double or blurred vision
□ Corrective glasses/contacts

EMOTIONAL
□ Emotional illness
□ Depression
□ Anxiety
□ Feelings of worthlessness
□ Physical abuse
□ Frequent nightmares
□ Hysterical attacks
□ Difficulty sleeping

MALE
□ Abnormality of testicles
□ Varicocele
□ Difficulty in sexual function
□ Genital pain
□ Plastic Surgery

FEMALE
□ Breast pain
□ Breast implants/reduction
□ Uterine fibroids/tumors
□ Painful menses/excessive bleeding
□ Genital pain
□ Difficulty in sexual function
□ Plastic Surgery

Patient Signature: _____ Date: _____