



Pruitt Chiropractic Clinic

11943 Cumming Hwy * Canton, GA 30115 * Telephone 770-887-7618 * Fax 770-887-5961

Patient _____ # _____

CHECK ANY OF THE FOLLOWING THAT YOU HAVE HAD IN THE PAST...

- | | | | | |
|--|--------------------------------------|-------------------------------------|---------------------------------------|---|
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Measles | <input type="checkbox"/> Mumps | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Depression | <input type="checkbox"/> Drug Problem | <input type="checkbox"/> Venereal Disease |

CHECK ANY OF THE FOLLOWING CONDITIONS THAT YOU HAVE HAD RECENTLY...

General Symptoms:

- | | | | | |
|--|---------------------------------------|--------------------------------------|---|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Colds/Fevers | <input type="checkbox"/> Influenza | <input type="checkbox"/> Fainting | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Loss of Taste |
| <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Weight Gain | <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Drug Allergies | <input type="checkbox"/> Respiratory Allergies |

Cardiovascular:

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Arrhythmia | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Poor Circulation | <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Cold Hands/Feet | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Swollen Ankles | <input type="checkbox"/> Previous Stroke | <input type="checkbox"/> Anemia | <input type="checkbox"/> High Cholesterol |

Respiratory:

- | | | | |
|--|-----------------------------------|--|---|
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Chronic Cough | <input type="checkbox"/> Breathing Difficulty |
| <input type="checkbox"/> Spitting Up Blood | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Tuberculosis |

Eyes/Ears/Nose/Throat:

- | | | | |
|--|---|--------------------------------------|---|
| <input type="checkbox"/> Poor Vision | <input type="checkbox"/> Eye Pain/Infection | <input type="checkbox"/> Nose Bleeds | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Post Nasal Drip | <input type="checkbox"/> Sore Throats | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Ear Ache/Infection |
| <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Asthma | <input type="checkbox"/> Thyroid Problem |

Gastro-Intestinal:

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Nausea | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Reflux/Heartburn | <input type="checkbox"/> Intestinal Gas | <input type="checkbox"/> Indigestion |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Liver Problem | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Blood in stool |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Constipation | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Gall Bladder Problem |

Genito-Urinary:

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Urinary Frequency | <input type="checkbox"/> Painful Urination | <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Kidney Infections |
| <input type="checkbox"/> Incontinence | <input type="checkbox"/> Blood/Pus in Urine | <input type="checkbox"/> Prostate Problem | <input type="checkbox"/> Bladder Infections |

Muscle & Joint:

- | | | | |
|--|---|---------------------------------------|--|
| <input type="checkbox"/> Neck Pain/Stiffness | <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Arm Pain | <input type="checkbox"/> Mid-Back Pain |
| <input type="checkbox"/> Lower Back Pain | <input type="checkbox"/> Disc Problem | <input type="checkbox"/> Leg Pain | <input type="checkbox"/> Numbness/Tingling |
| <input type="checkbox"/> Painful Tailbone | <input type="checkbox"/> Spinal Curvature | <input type="checkbox"/> Foot Problem | <input type="checkbox"/> Arthritis |

Skin:

- | | | | |
|------------------------------------|--|---|---|
| <input type="checkbox"/> Eruptions | <input type="checkbox"/> Itching/Dryness | <input type="checkbox"/> Eczema | <input type="checkbox"/> Bruises Easily |
| <input type="checkbox"/> Boils | <input type="checkbox"/> Hives | <input type="checkbox"/> Skin Allergies | <input type="checkbox"/> Sensitive Skin |

PLEASE READ THE FOLLOWING AND SIGN AT THE SPACE PROVIDED

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I also understand that the doctor's office will assist me in collecting from the insurance company, except when the doctor accepts assignment, and that any amount authorized to be paid directly to the doctor will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that any fees for professional services rendered me will be due and payable immediately if I suspend or terminate my care. My signature constitutes permission to treat me or my family member.

Patient (or Guardian) Signature _____ Date _____