

SILVA CHIROPRACTIC & NUTRITION

Case History

Patient Name: _____

Date: _____

Do you or have you had any of the following?

HIV Positive/AIDS	yes	no	Disc Bulge/Herniation	yes	no
Rheumatoid Arthritis	yes	no	Neck or Back Surgery	yes	no
Osteoarthritis/DJD	yes	no	Metal Implants	yes	no
Fibromyalgia	yes	no	Breast Implants	yes	no
Cancer	yes	no	Heart Disease	yes	no
Diabetes	yes	no	Mental Disorder/Depression	yes	no
Tuberculosis	yes	no	Osteoporosis	yes	no
High Blood Pressure	yes	no	Blocked Arteries	yes	no

Operations and Procedures:

(If you have had any of the following, please mark and give the approximate year)

_____ Appendectomy	_____ Tubes in Ears	_____ Sinus Surgery (or Septoplasty)
_____ Tonsillectomy	_____ Partial Hysterectomy	_____ Hernia Surgery
_____ Gall Bladder	_____ Total Hysterectomy	_____ Thyroid
_____ Back Surgery	_____ Rectal/hemorrhoid Surgery	_____ Stomach Surgery
_____ Implants (type: _____)	_____ Other _____	_____ NO SURGERIES

Please mark "C" for Currently or "P" for Past if you are or have suffered from one of the following conditions.

_____ Allergies	_____ Asthma	_____ Gall Bladder Problems
_____ Bronchitis	_____ Earache	_____ Hemorrhoids
_____ Dizziness/Fainting	_____ Ringing in the Ears	_____ Nausea
_____ Migraines	_____ Blood in Urine	_____ Vomiting Blood
_____ Headaches	_____ Frequent Urination	_____ High Blood Pressure
_____ Loss of Sleep	_____ Incontinence	_____ Low Blood Pressure
_____ Loss of Weight	_____ Painful Urination	_____ Poor Circulation
_____ Nervousness	_____ Constipation	_____ Previous Heart Trouble
_____ Night Sweats	_____ Diarrhea	_____ Strokes
_____ Chest Pain	_____ Varicose Veins	_____ Arteriosclerosis
_____ Fatigue	_____ Backaches	_____ Foot Trouble
_____ Pain Between Shoulders	_____ Stiff Neck	_____ Scoliosis
_____ Swollen Joints	_____ Muscle Weakness	
_____ Difficulty Breathing	_____ Painful Menstruation	
_____ Miscarriage	_____ Numbness/Pain in the arms/legs/hands/feet	

Family History: (Have any family members had the following conditions?)

_____ Heart Disease	_____ Diabetes	_____ Blood Disorder
_____ Stroke	_____ Arthritis	_____ TB
_____ High Blood Pressure	_____ Cancer	_____ Thyroid Disorders

Please Explain: _____