

Welcome to the Universal Health Method



Balance the body, mind, and spirit

Welcome to our office!

Please provide the following information as thoroughly as possible so that we can provide the best care. Thank you!

Name: _____

Occupation: _____

Address: _____

Employer: _____

City, State, Zip: _____

Address: _____

Telephone (home): _____ (office) _____

Work hours: _____

Age: _____ yrs. Date of birth: _____

School: _____

Social Security Number _____

Permanent Address/Phone _____

Circle all that apply:

Stable relationship Single Divorced Widowed Separated Children (#) _____

Previous chiropractors: _____

Current medical doctor: _____

Referred by: _____

Your major complaint or symptoms: _____

When did you first notice this? _____

Did this occur/start at work? _____ Accident? _____ Other: _____

Describe onset: _____

Have you ever felt the same or had a similar complaint? _____ When? _____

Is it getting worse? _____ better? _____ same? _____

Current treatment _____

By whom? _____

Previous treatment _____

By whom? _____

Out of work now? No ___ Yes ___ Since _____

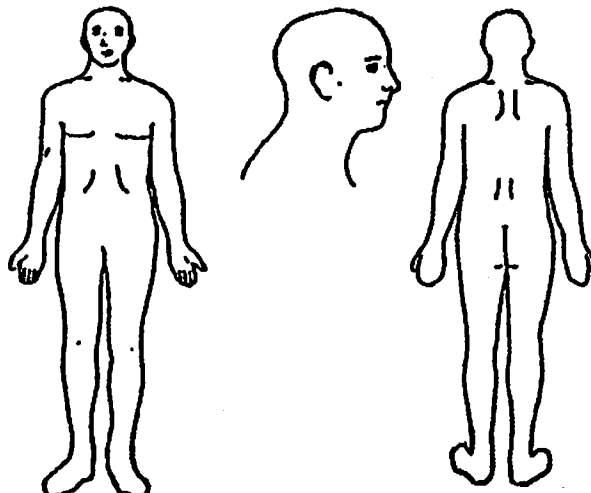
Other comments/information: _____

Other health problems you have now/often: _____

Other major health problems in the past: _____

Please mark areas of concern on the figures below.

O = dull pain X = sharp pain ::::: = numb



How is your blood pressure? _____

Other current treatments: _____

Current medication: _____

Other medication taken often: _____

Past surgeries: _____

Past accidents/injuries: _____

Broken bones: _____

Do you smoke? Y N Excess alcohol? Y N Recreational drugs? Y N Sleep well? Y N

Do you exercise regularly? Y N How often? _____ Doing what? _____

Please enter the following: N = never before B = had before R = Recently/presently experiencing

____ headaches

____ dizziness

____ ear noises

____ vision problems

____ hearing problems

____ confusion

____ depression

____ anger, unexplained

____ stress, unexplained

____ stiff neck

____ mid-back pain

____ low-back pain

____ numbness

____ stiff joints

____ weak muscles

____ convulsions

____ fatigue

____ fever

____ weight loss/gain

____ sweats

____ tremors

____ hemorrhoids

____ heart disease

____ hernia

____ allergies

____ asthma

____ chest pain

____ stomach pain

____ urination difficulty

____ bowel difficulty

____ painful swallow

____ very thirsty

____ coughing

____ frequent colds

____ sinus problems

____ sore throats

____ recurrent infections

____ prostate problems

____ gall bladder

____ alcoholism

____ anemia

____ arteriosclerosis

____ cancer

____ diabetes (I or II)

____ epilepsy

____ gout

____ multiple sclerosis

____ polio

____ rheumatic fever

____ stroke

____ tuberculosis

____ ulcer

____ venereal disease

WOMEN ONLY:

Period:

____ regular

____ irregular

____ painful

____ not menstruating

____ Last breast exam (date)

____ Last pelvic exam (date)

____ Frequent pelvic pain?

____ Surgery?

____ Breast disease?

Pregnant now?

____ yes

____ no

____ unsure

This information is complete and true to the best of my knowledge. I agree to keep this office informed of any changes or developments in my health situation, or as it relates to treatment.

Signed _____ Date: _____