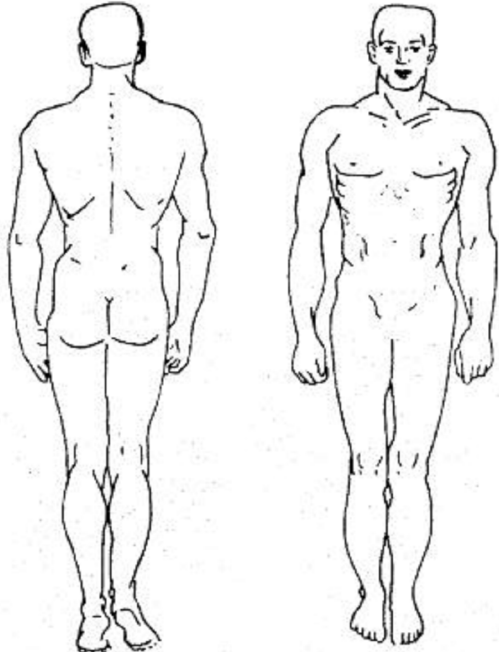


Name: _____

Date: _____

PLEASE MARK AN X ON THE DIAGRAM
BELOW WHERE YOUR PROBLEMS ARE



What hurts and how long has it hurt?

1. _____
2. _____
3. _____
4. _____

When do you think these problems originally started?

1. _____
2. _____
3. _____
4. _____

List other Chiropractic or Medical Doctors you have consulted for these conditions.

1. _____
2. _____
3. _____
4. _____

Check any of the following you have had in the last six months:

- | | |
|--------------------------------------------------------|--------------------------------------------------------|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Sinus Congestion / Allergies | <input type="checkbox"/> Frequent Nausea / Vomiting |
| <input type="checkbox"/> Vision Problems | <input type="checkbox"/> Abdominal Cramps |
| <input type="checkbox"/> Ear Aches | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Poor / Excessive Appetite |
| <input type="checkbox"/> Lung Problems / Congestion | <input type="checkbox"/> Excessive Thirst |
| <input type="checkbox"/> Blood Pressure Problems | <input type="checkbox"/> Painful / Excessive Urination |
| <input type="checkbox"/> Ankle Swelling | <input type="checkbox"/> Discolored Urine |
| <input type="checkbox"/> Prostate / Sexual Dysfunction | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Menstrual Cycle Dysfunction | <input type="checkbox"/> Cancer |

Pregnancy Release:

This is to certify that to the best of my knowledge I am not pregnant and Dr. Espinosa and his associates have my permission to perform an x-ray evaluation.

Date of last menstrual cycle _____

Signature _____

Date _____