Dr. Edward Koen, D.C. Samaritan Chiropractic, LLC 634 NW 4th Street, Corvallis Oregon 97330 541-752-0776

Have you ever suffered from: Albop/HIV Excessive menstruation Nose Bleeds Alcoholism Excessive menstruation Nose Bleeds Allergies Fatigue Polio Arthritis Frequent urination Poor posture Asthma Headache Prostate Problems Sciatica Breast Lump High Blood Pressure Shortness of breath Gronchitis Hot Flashes Sinus Infection Spinal Curvatures Cancer Irregular Heart Beat Spinal Curvatures Somohitis Hot Flashes Stroke Sould Extremities Constipation Kidney Infection Swelling of ankles Gramps Depression Kidney Songes Dispettes Loss of Balance Tuberculosis Ucers User Songes Dispettes Loss of Smell Ulcers Deep Vein Thrombus Loss of Taste Varicose veins Ear ringing Neck Pain or stiffness Other Have you been treated for any conditions in the last year? Yes No Hyes, please describe Day unda X-rays taken? Yes No
□ Alcoholism □ Excessive menstruation □ Nose Bleeds □ Allergies □ Excessive menstruation □ Polio □ Anemia Arteriosclerosis □ Fatigue □ Polio □ Arthritis □ Frequent urination □ Poor posture □ Asthma □ Headache □ Prostate Problems □ Back Pain □ Hemorrhoids □ Sciatica □ Breast Lump □ High Blood Pressure □ Shortness of breath □ Bronchitis □ Hot Flashes □ Sinus Infection □ Cancer □ Irregular Heart Beat □ Spinal Curvatures □ Clo Extremities Constipation □ Kidney Infection □ Swelling of ankles □ Clo Extremities Constipation □ Kidney Stones □ Swelling of ankles □ Diabetes □ Loss of Memory □ Tuperculosis □ Diabetes □ Loss of Smell □ Ulcers □ Diapetes □ Loss of Smell □ Ulcers □ Dep Vein Thrombus □ Loss of Smell □ Ulcers □ Dep Vein Thrombus □ Loss of Smell □ Ulcers □ Dep Vein Thrombus □ Loss of Smell □ Ulcers □ Day uhave an implanted pacemaker or AICD? Yes □ No Have you had
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Medications you are taking and for what conditions: Vitamins, minerals, or herbs you are taking and for what condition Do you wear orthotics? Yes No Yes Briefly explain
Vitamins, minerals, or herbs you are taking and for what condition Do you wear orthotics?
Do you wear orthotics? I YesNoIf yes, please specify:Have you everNoYesBriefly explain
Do you wear orthotics? I YesNoIf yes, please specify:Have you everNoYesBriefly explain
Do you wear orthotics? I YesNoIf yes, please specify:Have you everNoYesBriefly explain
Have you ever No Yes Briefly explain
Have you ever No Yes Briefly explain
Broken Bones?
Been hospitalized?
Been in an auto accident?
Had sprains/strains?
Been struck unconscious?
Had surgery?
Habits None Light Moderate Heavy None Light Moderate Heavy
Alcohol
Coffee Soft Drinks Soft Drinks
Tobacco
Drugs
Exercise Image: Supervision of the supervisio
Sleep Image: Sleep <th< td=""></th<>
Family Medical History:
Do you have a blood relative living or diseased with any of the following? Please check.

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Symptoms:	No	Yes
Do you experience pain every day?		
Do your symptoms affect the quality of your life?		
Does your pain wake you up at night?		
Are your symptoms worse during certain times of the day?		
What activities aggravate your symptoms?		



