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

Have you ever suffered from: <ul> <li>Albop/HIV</li> <li>Excessive menstruation</li> <li>Nose Bleeds</li> <li>Alcoholism</li> <li>Excessive menstruation</li> <li>Nose Bleeds</li> <li>Allergies</li> <li>Fatigue</li> <li>Polio</li> <li>Arthritis</li> <li>Frequent urination</li> <li>Poor posture</li> <li>Asthma</li> <li>Headache</li> <li>Prostate Problems</li> <li>Sciatica</li> <li>Breast Lump</li> <li>High Blood Pressure</li> <li>Shortness of breath</li> <li>Gronchitis</li> <li>Hot Flashes</li> <li>Sinus Infection</li> <li>Spinal Curvatures</li> <li>Cancer</li> <li>Irregular Heart Beat</li> <li>Spinal Curvatures</li> <li>Somohitis</li> <li>Hot Flashes</li> <li>Stroke</li> <li>Sould Extremities Constipation</li> <li>Kidney Infection</li> <li>Swelling of ankles</li> <li>Gramps Depression</li> <li>Kidney Songes</li> <li>Dispettes</li> <li>Loss of Balance</li> <li>Tuberculosis</li> <li>Ucers</li> <li>User Songes</li> <li>Dispettes</li> <li>Loss of Smell</li> <li>Ulcers</li> <li>Deep Vein Thrombus</li> <li>Loss of Taste</li> <li>Varicose veins</li> <li>Ear ringing</li> <li>Neck Pain or stiffness</li> <li>Other</li> </ul> <li>Have you been treated for any conditions in the last year?</li> <li>Yes<ul> <li>No</li> <li>Hyes, please describe</li> <li>Day unda X-rays taken?</li> <li>Yes</li> <li>No</li></ul></li>
□ 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? <b>Yes</b> □ No         Have you had
□ Allergies       □ Eye conditions       □ Pneumonia         □ Anemia Arteriosclerosis       □ Fatigue       □ Polio         □ Arthritis       □ Frequent urination       □ Poor posture         □ Asthma       □ Headache       □ Prostate Problems         □ Back Pain       □ Hemorrhoids       □ Sciatica         □ Bronchitis       □ Hot Flashes       □ Shortness of breath         □ Cancer       □ Irregular Heart Beat       □ Spinal Curvatures         □ Chest Pain       □ Irregular Heart Beat       □ Swelling of ankles         □ Cancer       □ Irregular Uycle       □ Stroke         □ Cold Extremities Constipation       □ Kidney Stones       □ Swelling of ankles         □ Diabetes       □ Loss of Memory       □ Thyroid conditions         □ Diabetes       □ Loss of Smell       □ Ulcers         □ Diapetions       □ Loss of Taste       □ Varicose veins         □ Irregular theart stering       □ Neck Pain or stiffness       □ Other         Have you been treated for any conditions in the last year?       □ Yes       No         If yes, please describe       No       If yes, where?       No         Dato of last physical exam:       /       Is there a chance that you are pregnant? □Yes       No         Have you had X-rays takken?       <
Anemia Arteriosclerosis       Fatigue       Polio         Arthritis       Frequent urination       Poor posture         Arthritis       Frequent urination       Poor posture         Arthritis       Frequent urination       Poor posture         Arthritis       Headache       Prostate Problems         Back Pain       Headache       Shortness of breath         Breast Lump       High Blood Pressure       Shortness of breath         Bronchitis       Hot Flashes       Sinus Infection         Cancer       Irregular Heart Beat       Spinal Curvatures         Chest Pain       Irregular Cycle       Stroke         Cold Extremities Constipation       Kidney Infection       Swelling of ankles         Cramps Depression       Kidney Stones       Swollen Joints         Diagestion Problems       Loss of Memory       Thyroid conditions         Digestion Problems       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, where?       Do you have an implanted pacemaker or AICD?       Yes       No         Have you ha
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         Chest Pain       Irregular Cycle       Stroke         Cold Extremities Constipation       Kidney Infection       Swelling of ankles         Diabetes       Loss of Memory       Thyroid conditions         Diabetes       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         Have you had X-rays taken?       Yes       No       No         Medications you are taking and for what conditions:
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         □ Chest Pain       □ Irregular Cycle       □ Stroke         □ Catps Depression       □ Kidney Infection       □ Swelling of ankles         □ Diabetes       □ Loss of Memory       □ Thyroid conditions         □ Digestion Problems       □ Loss of Balance       □ Tuberculosis         □ Digestion Problems       □ Loss of Taste       □ Varicose veins         □ Dep Vein Thrombus       □ Loss of Taste       □ Varicose veins         □ Bare finging       □ Neck Pain or stiffness       □ Other         Have you been treated for any conditions in the last year?       □ Yes       No         Have you had X-rays taken?       □ Yes       □ No       If yes, please describe         Do you have an implanted pacemaker or AICD?       □ Yes       No         Witamins, minerals, or herbs you are taking and for what condition
□       Back Pain       □       Hemorrhoids       □       Sciatica         □       Breast Lump       □       High Blood Pressure       □       Shortness of breath         □       Bronchitis       □       Hot Flashes       □       Sinus Infection         □       Cancer       □       Irregular Heart Beat       □       Spinal Curvatures         □       Cancer       □       Irregular Cycle       □       Stroke         □       Cancer       □       Irregular Cycle       □       Swelling of ankles         □       Cancer       □       Kidney Infection       □       Swelling of ankles         □       Cancerson       □       Kidney Stones       □       Swelling of ankles         □       Diabetes       □       Loss of Memory       □       Thyroid conditions         □       Diagestion Problems       □       Loss of Smell       □       Ulcers         □       Deep Vein Thrombus       □       Loss of Taste       □       Varicose veins         □       Is there a chance that you are pregnant?       □Yes       No         Have you had X-rays taken?       □ Yes       No         Medications you are taking and for what conditions:
Breast Lump       High Blood Pressure       Shortness of breath         Bronchitis       Hot Flashes       Sinus Infection         Cancer       Irregular Heart Beat       Spinal Curvatures         Chest Pain       Irregular Cycle       Stroke         Cold Extremities Constipation       Kidney Infection       Swelling of ankles         Caraps Depression       Kidney Stones       Swollen Joints         Diabetes       Loss of Memory       Thyroid conditions         Dizziness       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         Have you had X-rays taken?       Yes       No       If yes, where?         Do you have an implanted pacemaker or AICD?       Yes       No         Medications you are taking and for what conditions       If yes, please describe       Image: No         Do you wear orthotics?       Yes       No       If yes, please specify:         Have you ever       No       Yes       Briefly explain
Bronchitis       □ Hot Flashes       □ Sinus Infection         □ Cancer       □ Irregular Heart Beat       □ Spinal Curvatures         □ Chest Pain       □ Irregular Cycle       □ Stroke         □ Cold Extremities Constipation       □ Kidney Infection       □ Swelling of ankles         □ Cramps Depression       □ Kidney Stones       □ Swollen Joints         □ Diabetes       □ Loss of Memory       □ Thyroid conditions         □ Digestion Problems       □ Loss of Smell       □ Ulcers         □ Dizziness       □ 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         Have you have an implanted pacemaker or AICD?       □ Yes       No         Medications you are taking and for what conditions:
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Chest Pain       Irregular Cycle       Stroke         Cold Extremities Constipation       Kidney Infection       Swelling of ankles         Diabetes       Kidney Stones       Swollen Joints         Diabetes       Loss of Memory       Thyroid conditions         Digestion Problems       Loss of Smell       Ulcers         Dizziness       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         Have you had X-rays taken?       Yes       No       If yes, where?         Do you wear orthotics?       Yes       No       If yes, please specify:         Have you ever       No       Yes       Briefly explain
Cold Extremities Constipation       Kidney Infection       Swelling of ankles         Cramps Depression       Kidney Stones       Swollen Joints         Diabetes       Loss of Memory       Thyroid conditions         Digestion Problems       Loss of Balance       Tuberculosis         Dizziness       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         Have you had X-rays taken?       Yes       No       If yes, where?         Do you have an implanted pacemaker or AICD?       Yes       No         Medications you are taking and for what conditions:
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□ Diabetes       □ Loss of Memory       □ Thyroid conditions         □ Digestion Problems       □ Loss of Balance       □ Tuberculosis         □ Diziness       □ 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         If yes, please describe       □       □ Is there a chance that you are pregnant?       □ Yes       □ No         Have you had X-rays taken?       □ Yes       □ No       If yes, where?       □       No         Do you have an implanted pacemaker or AICD?       □ Yes       □ No       No       Medications you are taking and for what condition
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□ Dizziness □ 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   If yes, please describe □ Is there a chance that you are pregnant? □ Yes   Date of last physical exam: / / Is there a chance that you are pregnant? □ Yes   No Have you had X-rays taken? □ Yes □ No   Medications you are taking and for what conditions:
<ul> <li>Deep Vein Thrombus</li> <li>Loss of Taste</li> <li>Neck Pain or stiffness</li> <li>Other</li> <li>Have you been treated for any conditions in the last year?</li> <li>Yes</li> <li>No</li> <li>If yes, please describe</li> <li>Date of last physical exam:</li> <li>/</li> <li>Is there a chance that you are pregnant?</li> <li>Yes</li> <li>No</li> <li>If yes, please dascribe</li> <li>Do you have an implanted pacemaker or AICD?</li> <li>Yes</li> <li>No</li> <li>Medications you are taking and for what conditions:</li> <li>Vitamins, minerals, or herbs you are taking and for what condition</li> <li>Do you wear orthotics?</li> <li>Yes</li> <li>No</li> <li>If yes, please specify:</li> <li>Have you ever</li> <li>No</li> <li>Yes</li> <li>Briefly explain</li> </ul>
□ Ear ringing □ Neck Pain or stiffness □ Other   Have you been treated for any conditions in the last year? □ Yes No   If yes, please describe Is there a chance that you are pregnant? □ Yes   Date of last physical exam: / / Is there a chance that you are pregnant? □ Yes   Have you had X-rays taken? □ Yes No If yes, where?   Do you have an implanted pacemaker or AICD? □ Yes No   Medications you are taking and for what conditions:
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If yes, please describe   Date of last physical exam:   /   Is there a chance that you are pregnant?   Yes   No   Have you had X-rays taken?   Yes   No   If yes, where?   Do you have an implanted pacemaker or AICD?   Yes   No   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   If yes, please specify:   Have you ever   No   Yes   Briefly explain
Date of last physical exam:       /       /       Is there a chance that you are pregnant?       IYes       No         Have you had X-rays taken?       IYes       No       If yes, where?         Do you have an implanted pacemaker or AICD?       IYes       No         Medications you are taking and for what conditions:
Have you had X-rays taken?       Yes       No       If yes, where?         Do you have an implanted pacemaker or AICD?       Yes       No         Medications you are taking and for what conditions:
Do you have an implanted pacemaker or AICD?       Yes       No         Medications you are taking and for what conditions:
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?		



