

# Confidential Health Report

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Name
Date

Please check the appropriate box for any of the following symptoms which you now have or have had previously.

<p><b>GENERAL</b></p> <p><input type="checkbox"/> Allergy <input type="checkbox"/> Now</p> <p><input type="checkbox"/> Chills <input type="checkbox"/> Now</p> <p><input type="checkbox"/> Convulsions <input type="checkbox"/> Now</p> <p><input type="checkbox"/> Dizziness <input type="checkbox"/> Now</p> <p><input type="checkbox"/> Fainting <input type="checkbox"/> Now</p> <p><input type="checkbox"/> Fatigue <input type="checkbox"/> Now</p> <p><input type="checkbox"/> Fever <input type="checkbox"/> Now</p> <p><input type="checkbox"/> Headache <input type="checkbox"/> Now</p> <p><input type="checkbox"/> Loss of Sleep <input type="checkbox"/> Now</p> <p><input type="checkbox"/> Loss of Weight <input type="checkbox"/> Now</p> <p><input type="checkbox"/> Nervousness <input type="checkbox"/> Now</p> <p><input type="checkbox"/> Depression <input type="checkbox"/> Now</p> <p><input type="checkbox"/> Numbness <input type="checkbox"/> Now</p> <p><input type="checkbox"/> Sweats <input type="checkbox"/> Now</p> <p><input type="checkbox"/> Tremors <input type="checkbox"/> Now</p> <p><b>MUSCLE &amp; JOINT</b></p> <p><input type="checkbox"/> Bursitis <input type="checkbox"/> Now</p> <p><input type="checkbox"/> Foot Trouble <input type="checkbox"/> Now</p> <p><input type="checkbox"/> Hernia <input type="checkbox"/> Now</p> <p><input type="checkbox"/> Low back pain <input type="checkbox"/> Now</p> <p><input type="checkbox"/> Neck pain or stiffness <input type="checkbox"/> Now</p> <p><input type="checkbox"/> Pain between shoulders <input type="checkbox"/> Now</p> <p><input type="checkbox"/> Painful tail bone <input type="checkbox"/> Now</p> <p><input type="checkbox"/> Poor posture <input type="checkbox"/> Now</p> <p><input type="checkbox"/> Sciatica <input type="checkbox"/> Now</p> <p><input type="checkbox"/> Spinal Curvature <input type="checkbox"/> Now</p> <p><input type="checkbox"/> Swollen joints <input type="checkbox"/> Now</p> <p><b>SKIN</b></p> <p><input type="checkbox"/> Boils <input type="checkbox"/> Now</p> <p><input type="checkbox"/> Bruise easily <input type="checkbox"/> Now</p> <p><input type="checkbox"/> Dryness <input type="checkbox"/> Now</p> <p><input type="checkbox"/> Hives or allergy <input type="checkbox"/> Now</p> <p><input type="checkbox"/> Itching <input type="checkbox"/> Now</p> <p><input type="checkbox"/> Skin eruptions (rash) <input type="checkbox"/> Now</p> <p><input type="checkbox"/> Varicose veins <input type="checkbox"/> Now</p> <p><b>GASTRO-INTESTINAL</b></p> <p><input type="checkbox"/> Belching or gas <input type="checkbox"/> Now</p>	<p><input type="checkbox"/> Colitis <input type="checkbox"/> Now</p> <p><input type="checkbox"/> Colon trouble <input type="checkbox"/> Now</p> <p><input type="checkbox"/> Constipation <input type="checkbox"/> Now</p> <p><input type="checkbox"/> Diarrhea <input type="checkbox"/> Now</p> <p><input type="checkbox"/> Difficult digestion <input type="checkbox"/> Now</p> <p><input type="checkbox"/> Distension of abdomen <input type="checkbox"/> Now</p> <p><input type="checkbox"/> Excessive hunger <input type="checkbox"/> Now</p> <p><input type="checkbox"/> Gall bladder trouble <input type="checkbox"/> Now</p> <p><input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Now</p> <p><input type="checkbox"/> Intestinal worms <input type="checkbox"/> Now</p> <p><input type="checkbox"/> Jaundice <input type="checkbox"/> Now</p> <p><input type="checkbox"/> Liver trouble <input type="checkbox"/> Now</p> <p><input type="checkbox"/> Nausea <input type="checkbox"/> Now</p> <p><input type="checkbox"/> Pain over stomach <input type="checkbox"/> Now</p> <p><input type="checkbox"/> Poor Appetite <input type="checkbox"/> Now</p> <p><input type="checkbox"/> Vomiting <input type="checkbox"/> Now</p> <p><input type="checkbox"/> Vomiting of blood <input type="checkbox"/> Now</p> <p><b>EYES, EARS, NOSE &amp; THROAT</b></p> <p><input type="checkbox"/> Asthma <input type="checkbox"/> Now</p> <p><input type="checkbox"/> Colds <input type="checkbox"/> Now</p> <p><input type="checkbox"/> Crossed eyes <input type="checkbox"/> Now</p> <p><input type="checkbox"/> Deafness <input type="checkbox"/> Now</p> <p><input type="checkbox"/> Dental decay <input type="checkbox"/> Now</p> <p><input type="checkbox"/> Earache <input type="checkbox"/> Now</p> <p><input type="checkbox"/> Ear discharge <input type="checkbox"/> Now</p> <p><input type="checkbox"/> Ear noises <input type="checkbox"/> Now</p> <p><input type="checkbox"/> Enlarged glands <input type="checkbox"/> Now</p> <p><input type="checkbox"/> Enlarged thyroid <input type="checkbox"/> Now</p> <p><input type="checkbox"/> Eye pain <input type="checkbox"/> Now</p> <p><input type="checkbox"/> Failing vision <input type="checkbox"/> Now</p> <p><input type="checkbox"/> Far sightedness <input type="checkbox"/> Now</p> <p><input type="checkbox"/> Gum trouble <input type="checkbox"/> Now</p> <p><input type="checkbox"/> Hay fever <input type="checkbox"/> Now</p> <p><input type="checkbox"/> Hoarseness <input type="checkbox"/> Now</p> <p><input type="checkbox"/> Nasal obstruction <input type="checkbox"/> Now</p> <p><input type="checkbox"/> Near sightedness <input type="checkbox"/> Now</p> <p><input type="checkbox"/> Nosebleeds <input type="checkbox"/> Now</p> <p><input type="checkbox"/> Sinus Infection <input type="checkbox"/> Now</p>	<p><input type="checkbox"/> Sore throat <input type="checkbox"/> Now</p> <p><input type="checkbox"/> Tonsillitis <input type="checkbox"/> Now</p> <p><b>CARDIOVASCULAR</b></p> <p><input type="checkbox"/> Hardening of arteries <input type="checkbox"/> Now</p> <p><input type="checkbox"/> High blood pressure <input type="checkbox"/> Now</p> <p><input type="checkbox"/> Low blood pressure <input type="checkbox"/> Now</p> <p><input type="checkbox"/> Pain over heart <input type="checkbox"/> Now</p> <p><input type="checkbox"/> Poor circulation <input type="checkbox"/> Now</p> <p><input type="checkbox"/> Rapid heart beat <input type="checkbox"/> Now</p> <p><input type="checkbox"/> Slow heart rate <input type="checkbox"/> Now</p> <p><input type="checkbox"/> Swelling of ankles <input type="checkbox"/> Now</p> <p><b>RESPIRATORY</b></p> <p><input type="checkbox"/> Chest pain <input type="checkbox"/> Now</p> <p><input type="checkbox"/> chronic cough <input type="checkbox"/> Now</p> <p><input type="checkbox"/> Difficult breathing <input type="checkbox"/> Now</p> <p><input type="checkbox"/> Spitting up blood <input type="checkbox"/> Now</p> <p><input type="checkbox"/> Spitting up phlegm <input type="checkbox"/> Now</p> <p><input type="checkbox"/> Wheezing <input type="checkbox"/> Now</p> <p><b>GENITO-URINARY</b></p> <p><input type="checkbox"/> Bed-wetting <input type="checkbox"/> Now</p> <p><input type="checkbox"/> Blood in urine <input type="checkbox"/> Now</p> <p><input type="checkbox"/> Frequent urination <input type="checkbox"/> Now</p> <p><input type="checkbox"/> Inability to control kidneys <input type="checkbox"/> Now</p> <p><input type="checkbox"/> Kidney infection or stones <input type="checkbox"/> Now</p> <p><input type="checkbox"/> Painful urination <input type="checkbox"/> Now</p> <p><input type="checkbox"/> Prostate trouble <input type="checkbox"/> Now</p> <p><input type="checkbox"/> Pus in urine <input type="checkbox"/> Now</p> <p><b>FOR WOMEN ONLY</b></p> <p><input type="checkbox"/> Congested breasts <input type="checkbox"/> Now</p> <p><input type="checkbox"/> Cramps or backache <input type="checkbox"/> Now</p> <p><input type="checkbox"/> Excessive menstrual flow <input type="checkbox"/> Now</p> <p><input type="checkbox"/> Hot flashes <input type="checkbox"/> Now</p> <p><input type="checkbox"/> Irregular cycle <input type="checkbox"/> Now</p> <p><input type="checkbox"/> Menopausal symptoms <input type="checkbox"/> Now</p> <p><input type="checkbox"/> Painful menstruation <input type="checkbox"/> Now</p> <p><input type="checkbox"/> Vaginal discharge <input type="checkbox"/> Now</p> <p><input type="checkbox"/> Pregnant <input type="checkbox"/> Now</p>
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**CHECK THE FOLLOWING CONDITIONS YOU HAVE HAD**

<p><input type="checkbox"/> Aids</p> <p><input type="checkbox"/> Alcoholism</p> <p><input type="checkbox"/> Anemia</p> <p><input type="checkbox"/> Appendicitis</p> <p><input type="checkbox"/> Arteriosclerosis</p> <p><input type="checkbox"/> Arthritis</p> <p><input type="checkbox"/> Cancer</p>	<p><input type="checkbox"/> Cold sores</p> <p><input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> Diptheria</p> <p><input type="checkbox"/> Eczema</p> <p><input type="checkbox"/> Emphysema</p> <p><input type="checkbox"/> Epilepsy</p> <p><input type="checkbox"/> Fever blisters</p>	<p><input type="checkbox"/> Goiter</p> <p><input type="checkbox"/> Gout</p> <p><input type="checkbox"/> Heart disease</p> <p><input type="checkbox"/> Influenza</p> <p><input type="checkbox"/> Lumbago</p> <p><input type="checkbox"/> Malaria</p> <p><input type="checkbox"/> Measles</p>	<p><input type="checkbox"/> Miscarriage</p> <p><input type="checkbox"/> Multiple sclerosis</p> <p><input type="checkbox"/> Mumps</p> <p><input type="checkbox"/> Pleurisy</p> <p><input type="checkbox"/> Pneumonia</p> <p><input type="checkbox"/> Polio</p> <p><input type="checkbox"/> Rheumatic fever</p>	<p><input type="checkbox"/> Scarlet fever</p> <p><input type="checkbox"/> Stroke</p> <p><input type="checkbox"/> Tuberculosis</p> <p><input type="checkbox"/> Typhoid fever</p> <p><input type="checkbox"/> Ulcers</p> <p><input type="checkbox"/> Venereal Disease</p> <p><input type="checkbox"/> Whooping cough</p>
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