Previous Health History

During the last year, has a doctor treated you for any health problem? ☐ Yes ☐ No If yes, please explain: _____

Have you ever received Chiropractic care? ☐ Yes ☐ No If yes, please list the doctor's name, location of office, and for what problems you were seen: _____

List the approximate dates of any accidents, operations, or serious injuries (including broken bones) you have had: _____

If you have ever been in an automobile accident, when? ☐ This Year ☐ Last Year ☐ Past 5 Years ☐ Over 5 Years

Please check off the following that have applied to you within the past 2 years:

☐ Went to a Health Spa ☐ Purchased Vitamins ☐ Purchased Health Foods ☐ Received a Massage

Family History

Ages of: Father_____ Mother_____ Children _____

Family Health Conditions (please check): Diabetes_____ Asthma_____ Liver Disease_____ Heart Disease_____

High Blood Pressure_____ Arthritis_____ Cancer (indicate type) _____

Personal History

Childhood Diseases (please check): Measles_____ Mumps_____ Chicken Pox_____ Other _____

Are you pregnant? ☐ Yes ☐ No Date of last period: ____/____/____

Date of Last Physical: ____/____/____ Findings:_____

Date of Last Chiropractic Exam: ____/____/____ Findings:_____

Have you ever been disabled? ☐ Yes, from _____ to _____ ☐ No

Have you ever been hospitalized? ☐ Yes, from _____ to _____ ☐ No

Please check off any of the following symptoms that you are presently suffering from:

☐ Headaches	☐ Insomnia	☐ Loss of Appetite	☐ Low Energy
☐ Migraines	☐ Constipation	☐ Hot Flashes	☐ Labored Breathing
☐ Dizziness	☐ Diarrhea	☐ Impotency	☐ Swelling
☐ Neck Pain	☐ Excessive Gas	☐ Overactive Bladder	☐ Sinusitis
☐ Blurred Vision	☐ Indigestion/Heartburn	☐ Urination Discomfort	☐ Anxiety
☐ Fainting	☐ Arm Pain/Numbness	☐ Shoulder Pain	☐ Loss of Hearing
☐ Memory Loss	☐ Leg Pain/Numbness	☐ Heart Palpitations	☐ Night Pain
☐ Other:			

Financial Responsibility

Who is responsible for your bill? ☐ I am ☐ Spouse (spouse's birthdate: _____/_____/_____)
☐ My Employer ☐ Insurance ☐ Other: _____

Insurance company's name and address: _____

If you are responsible for your health care fees, payment will be made by: ☐ Cash ☐ Check ☐ Credit Card

Your fees are due and payable at the time examinations, x-rays, and treatments are received unless other arrangements have been made in advance. X-rays remain property of this clinic.

I, the undersigned, hereby give permission for treatment.

Patient's Signature_____ Social Security Number_____-_____-_____ Date: _____/_____/_____