

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:

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