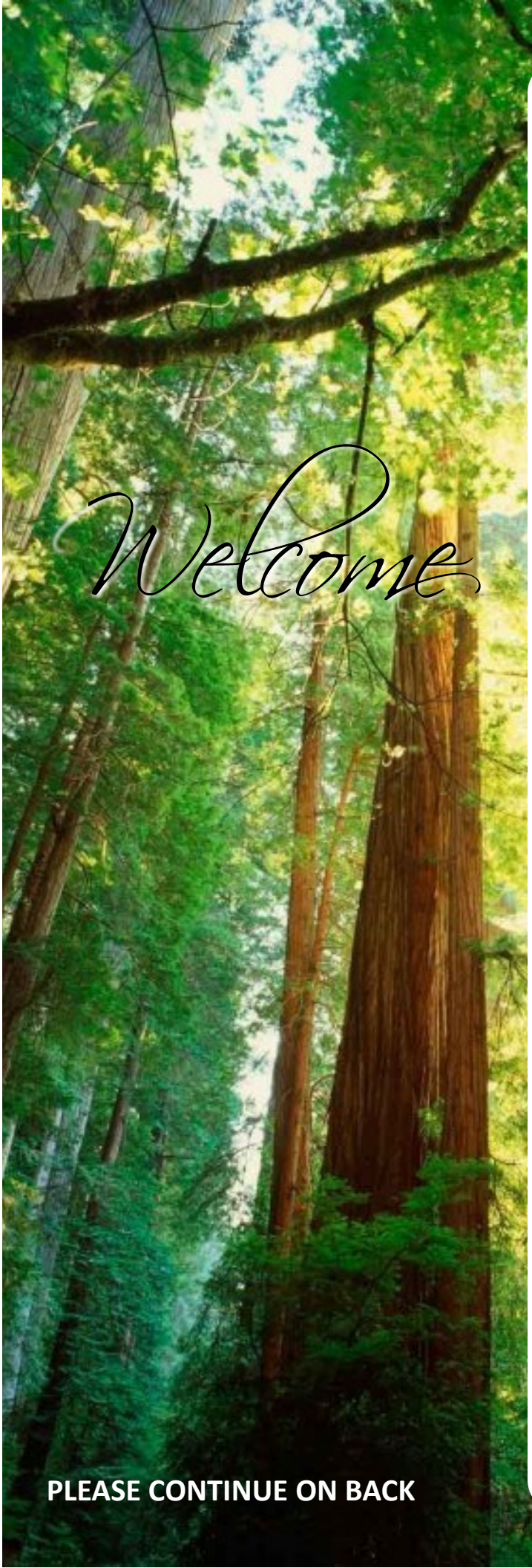


ABOUT YOU

Today's Date: _____/_____/_____

_____ _____
Last First

What You Prefer To Be Called: _____

❑ Male ❑ Female Birthday: _____/_____/_____ Age: ____

SS#: _____

Mailing Address: _____

_____ _____ _____
CITY STATE ZIP

Cell Phone: _____

Home Phone: _____

Work Phone: _____

Email Address: _____

Referred By: _____

Employer: _____

Occupation: _____

Spouse's Name: _____

Have you ever been treated by a Chiropractor? ❑ Yes ❑ No

IN EVENT OF EMERGENCY

Who should we contact?

_____

Relation: _____

Cell Phone: _____

Who is your Medical Doctor?

_____

RACE

❑ American Indian ❑ Asian ❑ African American

❑ Hispanic or Latino ❑ Hawaiian ❑ White

PLEASE CONTINUE ON BACK

REASON FOR VISIT

When did your condition/accident occur? _____/_____/____

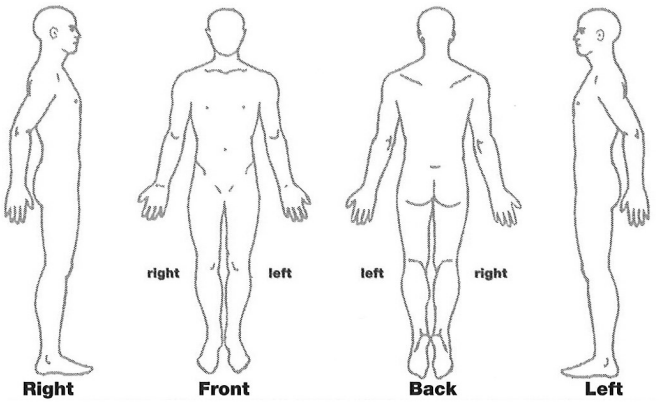
Please explain what happened:

_____

_____

_____

Using the body charts, please circle all affected areas -->



HEALTH HISTORY

Are you taking any of the following medications? ❑ Nerve pills ❑ Pain killers (including aspirin)

❑ Muscle relaxers ❑ Blood thinners ❑ Tranquilizers ❑ Insulin ❑ Other(s): _____

_____

Do you have or have you had any of the following diseases, medical conditions or procedures?

Y N Heart Attack / Stroke
Y N Mitral Valve Prolapse
Y N Venereal Disease
Y N Frequent Neck Pain
Y N High/Low Blood Pressure
Y N Severe / Frequent Headaches
Y N Sinus Problems
Y N Lower Back Problems

Y N Heart Surg./Pacemaker
Y N Artificial Valves
Y N Difficulty Breathing
Y N Glaucoma
Y N Psychiatric Problems
Y N Kidney Problems
Y N Emphysema / Asthma
Y N Artificial Bones/Joints/Implants

Y N Heart Murmur
Y N Cancer
Y N Shingles
Y N Arthritis
Y N Tuberculosis
Y N Ulcers / Colitis
Y N Hepatitis

Y N Congenital Heart Defect
Y N Alcohol / Drug Abuse
Y N HIV+ / AIDS / ARC
Y N Anemia / Diabetes
Y N Rheumatic Fever
Y N Fainting / Seizures / Epilepsy
Y N Chemotherapy

Please list any surgeries with dates and/or any other serious medical condition(s) not listed above:

_____

_____

Please list anything that you may be allergic to: _____

Family health history: _____

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____ Date _____/_____/_____

❑ Adult Patient ❑ Parent or Guardian ❑ Spouse