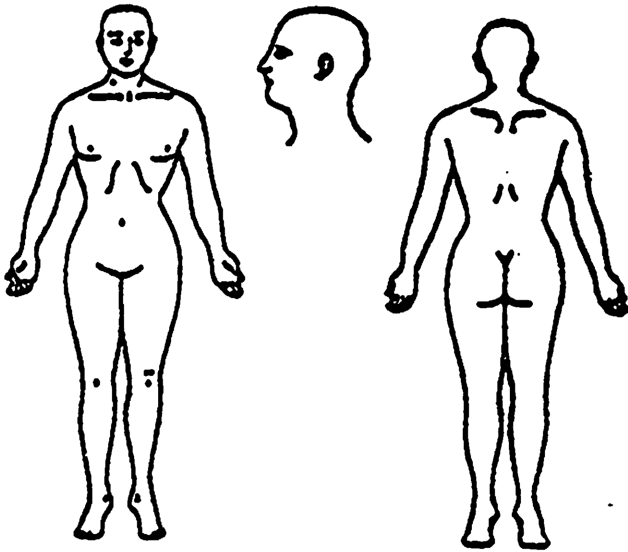
Date of Last Physical Examination ____________________

Please mark your areas of pain on the figures below.



Have you Ever Suffered From:

1. Dizziness ____________
2. Backaches ____________
3. Heart Trouble ____________
4. Diabetes ____________
5. Arthritis ____________
6. Headaches ____________
7. Asthma ____________
8. Neuritis ____________
9. Digestive Disorders ____________
10. Nervousness ____________
11. Sinus Trouble ____________
12. Neck Pain ____________

INSURANCE INFORMATION:

Is your condition due to an auto accident or job related injury? ______ Yes ______ No

Do you have Health Insurance? ______ Yes ______ No If yes.

Name of Company ____________________ Policy # ____________

Are you covered by Medicare? ______ Yes ______ No

If yes. Health Insurance # ____________________

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore. I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account on receipt. However. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment. any fees for professional services rendered me will be immediately due and payable.

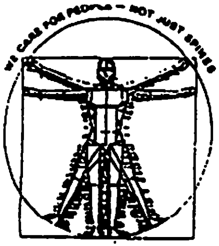
Patient's Signature ____________________

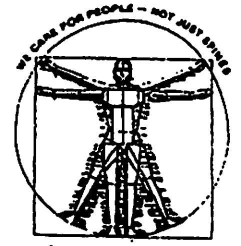
Guardian or Spouse's Signature: ____________________ Date: ________

Doctor's Signature ____________________

FAMILY HEALTH INFORMATION. (Many health problems are the result of hereditary spinal weaknesses: thus information about your family members will give us a better picture of your total health picture).

NAME	RELATION	PAST AND PRESENT HEALTH PROBLEMS





CONFIDENTIAL PATIENT CASE HISTORY

Please complete this history form. Your answers will help determine if chiropractic can help you. If we do not sincerely believe your condition will respond, we will not accept your case. THANK YOU.

NAME____HOME TELEPHONE____________________

ADDRESS____

AGE__________BIRTHDATE_______________MARITAL STATUS__________SPOUSE'S NAME_________

WORK PHONE_____________________CELL PHONE_____________________CELL CARRIER_________

E-MAIL ADDRESS____

OCCUPATION_____________________REFERRED BY____________________________________

HAVE YOU HAD PREVIOUS CHIROPRACTIC CARE?_____________

HEALTH INFORMTION:

MAJOR COMPLAINT:____

Other complaints:____

How long have you had condition__________Have you had similar condition?_________________

What activities aggravate condition?____

Is condition getting worse? Yes____NO____ Constant______ Comes and goes_______

Is condition interfering with your: Work______sleep________daily routine_______other__________

How long since you really felt good?____

Other doctors who have treated condition____

List surgical procedures and years____

Age of Mattress____________________Comfortable_____________Uncomfortable____________

Are you wearing: heel lifts_______sole lifts________inner soles________arch supports___________

Have you had an auto accident?_______Past year______Past 5 years________Over 5 years__________

Any other personal injuries or accidents____

Describe____