

Health History

Please list any medication (including pain killers) you are taking: _____

Please list any serious injuries or surgeries you have had in the last 10 years:

	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____
Other Serious Injuries	_____	_____

Women: Are you pregnant? Y N If so, how far along? _____ Nursing? Y N

Medical Conditions

Have you ever had or do you currently have any of the following medical conditions?

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Heart Attack/Stroke | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Ulcer/Colitis |
| <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Frequent Neck Pain | <input type="checkbox"/> Severe/Frequent Headaches | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Alcohol/Drug Abuse | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Diabetes/Tuberculosis | <input type="checkbox"/> Numbness, where? _____ |
| <input type="checkbox"/> Fainting/Seizures/Epilepsy | <input type="checkbox"/> Wrist Pain | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Tingling, where? _____ |
| <input type="checkbox"/> Shingles | <input type="checkbox"/> Shoulder Pain | <input checked="" type="checkbox"/> Emphysema/Glaucoma | <input type="checkbox"/> Muscle Spasms, where? _____ |
| <input type="checkbox"/> Psychiatric Problems | <input type="checkbox"/> Arm Pain | <input type="checkbox"/> Kidney Problems | |
| <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Leg Pain | <input type="checkbox"/> Artificial Bones/Joints | |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Lower Back Problems | <input type="checkbox"/> Cancer | |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Severe/Frequent Earaches | <input type="checkbox"/> HIV Positive/AIDS | |

Personal Habits

	Heavy	Moderate	Light	None
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the chiropractor to help determine appropriate and healthful chiropractic treatment. If there is any change in my medical status, I will inform the chiropractor.

I authorize my insurance company to pay to the chiropractor or chiropractic group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the chiropractor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____

Payment is due in full at time of treatment unless prior arrangements have been approved.