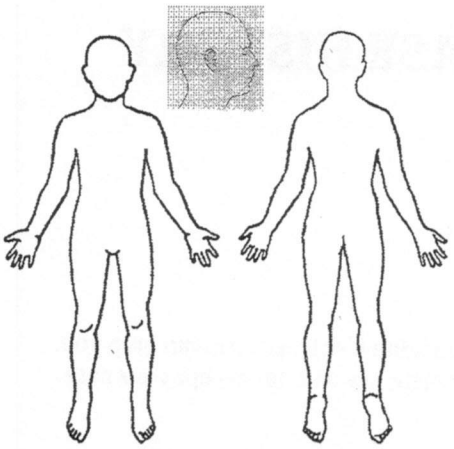

Have you ever suffered from:
(Check if applicable)

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

Vitals

Height: _____ Weight: _____

Please check one of the Following Below:

___Never a Smoker ____Current Smoker ____Every day Smoker ____Former Smoker ___Sometimes

Medication

Please list any **medications** and the **dosage** you are currently using:

_____

Allergies

Please List what you allergies that you may have: _____

Surgery

Have you had any surgeries? If so what were they? When? _____

Family History

Please list what kind of illnesses run in your family: _____

Social History

Smoking ___ Alcohol ____ Caffeine ____ Drug use ____ Exercise____ Other ____

INSURANCE INFORMATION:

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

Do you have Health Insurance? Yes No

Name of Company _____ **Policy #** _____

*** 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 Signature: _____ **Date:** _____

Guardian or Spouse's Signature: _____ Date: _____