Insurance Carrier:_____ Policy No.:_____

Agent:_____ Claims Office Address:_____

FOR OFFICE USE ONLY

_____

_____

_____

Confidential Health History

Dear Patient: This information is considered confidential. We need this information because we care enough to want to know, and your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form. Thank you.

PERSONAL:

Cell _____

Name:_____ (Name title, first name, and last name) Sex:_____ M or F Marital Status:_____ M,S,D,W Date of Birth: _____ month day year Home Phone: _____ Area Code Number

Address:_____ (Include street type, such as ST., AVE., etc.) City: _____ State: _____ Zip Code:_____

Your Occupation:_____ (If student, unemployed, retired, child, housewife, etc., please so indicate)

Who referred you to our office?_____

Social Sec. #:_____ Business Phone: _____ Area Code Number Company Name: _____ Location: _____

Spouse's First name: _____ Spouse's Soc. Sec. #: _____ Spouse's Employer: _____ Location: _____

HEALTH REPORT:

Email: _____

Is this visit for an annual physical? Yes ___ No ___ Height: Feet ____ Inches ____ Weight: _____

Please describe the principal health problems for which you came to this office. _____

_____

_____

List any other doctors seen for this: _____

_____

List any diagnosis(es) and type of treatment(s): _____

_____

Have you lost any days of work? Yes ___ No ___ Dates: _____

Have you had similar accidents or injuries before? Yes ___ No ___ If yes, explain: _____

_____

List the names of any relatives that have or have had a similar problem: _____

_____

Have you or any relative received chiropractic treatment previously? Yes ___ No ___ If yes, explain: _____

_____

Have you been treated for any health condition by a physician in the last year? Yes ___ No ___ If yes, explain: _____

_____

Are you currently under medication? Yes ___ No ___ If so, what kind? _____

Have you been under medication in the past? Yes ___ No ___ If so, what kind? _____

List the approximate dates of any surgery or unusual diseases you have had: _____

_____

If your condition is due to an accident, not work related, please answer the following: _____

Date _____ Time _____ AM ___ PM ___ of accident. Police report made? _____

Place - Location of accident: _____

Do you have an attorney that has advised you in this case? Yes ___ No ___ If yes, list the name and address: _____

_____

Please describe the accident: _____

_____

If your condition is due to a work-related accident, please answer the following:

Have you notified your employer? Yes ___ No ___ If yes, who or what department? _____

Date injured _____ Time _____ AM ___ PM ___ Date last worked _____

Injured at: _____ (Address, city, county, and state)

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Litho in U.S.A.

—OVER—

HEALTH QUESTIONNAIRE:

Please indicate for each of the questions below your experience by use of one of the following codes:
Codes: 1 for presently have; 2 for previously had

MUSCULO-SKELETAL SYSTEM

____ Low back problems
____ Pain between shoulders
____ Neck problems
____ Arm problems
____ Leg problems
____ Swollen joints
____ Painful joints
____ Stiff joints
____ Sore muscles
____ Weak muscles
____ Walking problems
____ Ruptures
____ Broken bones

GENITO-URINARY SYSTEM

____ Bladder trouble
____ Excessive urine
____ Scanty urination
____ Painful urination
____ Discolored urine

FEMALE

____ Vaginal discharge
____ Vaginal bleeding
____ Vaginal pain
____ Breast pain
____ Lumps on breast

Are you pregnant?
____ Yes ____ No

GASTRO-INTESTINAL SYSTEM

____ Poor appetite
____ Excessive hunger
____ Difficult chewing
____ Difficult swallowing
____ Excessive thirst
____ Nausea
____ Vomiting food
____ Vomiting blood
____ Abdominal pain
____ Diarrhea
____ Constipation
____ Black stool
____ Bloody stool
____ Hemorrhoids
____ Liver trouble
____ Gall bladder problems
____ Weight trouble

CARDIO-VASCULAR-RESPIRATORY

____ Chest pain
____ Pain over heart
____ Difficult breathing
____ Persistent cough
____ Coughing phlegm
____ Coughing blood
____ Rapid heartbeat
____ Blood pressure problems
____ Heart problems
____ Lung problems
____ Varicose veins

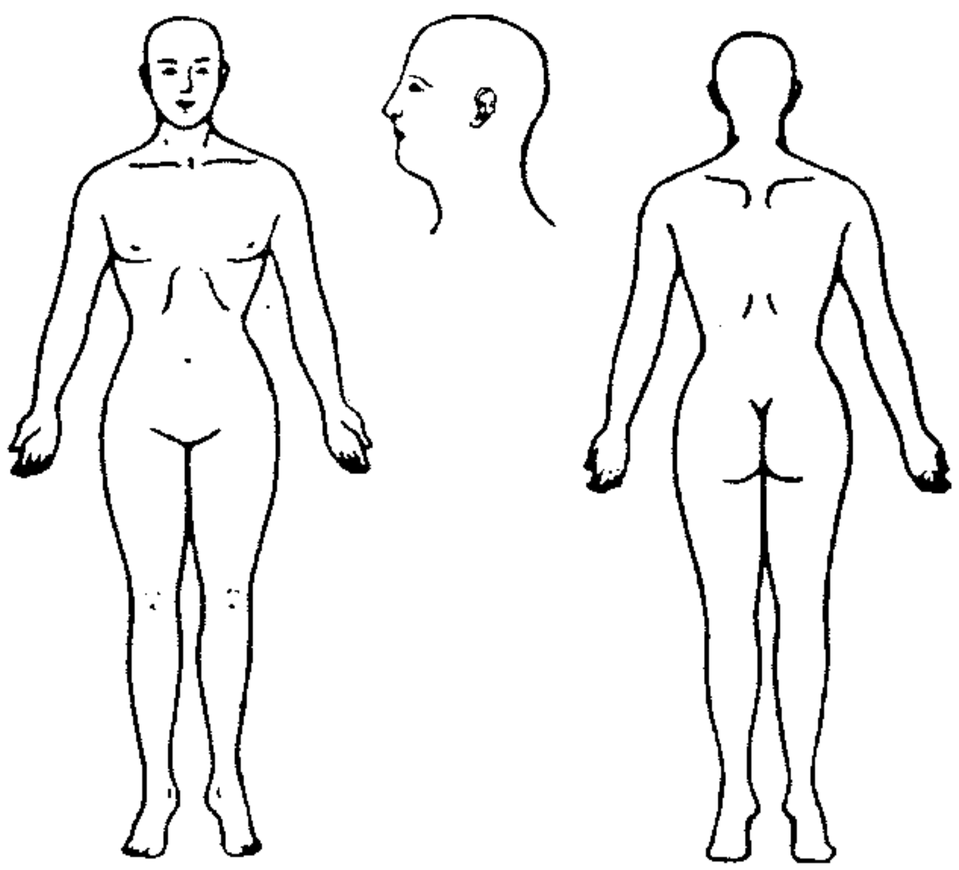
EYE, EAR, NOSE, AND THROAT

____ Eye strain
____ Eye inflammation
____ Vision problems
____ Ear pain
____ Ear noises
____ Hearing loss
____ Ear discharge
____ Nose pain
____ Nose bleeding
____ Nose discharge
____ Difficult breathing thru nose
____ Sore gums
____ Dental problems
____ Sore mouth
____ Sore throat
____ Hoarseness
____ Difficult speech

NERVOUS SYSTEM

____ Numbness
____ Loss of feeling
____ Paralysis
____ Dizziness
____ Fainting
____ Headaches
____ Muscle jerking
____ Convulsions
____ Forgetfulness
____ Confusion
____ Depression

Please mark your areas of pain on the figures below.



In case of emergency, please notify _____

address _____ phone _____

I understand that all treatments, X-rays and laboratory examinations are to be paid for as they are received or definite financial arrangements made in advance.

_____ _____
Patient's Signature Date

DO NOT WRITE BELOW THIS LINE

POP, PD, PS (F/A), FT, NOD, LOT, DOC, HP, AEP, NLW.

Patient accepted? Yes____ No____ Date_____ Doctor's signature _____