Please check the correct box for each item below. Check at least one box for each sign or symptom listed. ❑ Never; ❑ Previously; ❑ Presently.

GENERAL SYMPTOMS

Never	Previously	Presently		
❑	❑	❑	995.3	Allergy (What) _____
❑	❑	❑	491	Bronchitis
❑	❑	❑	780.9	Chills
❑	❑	❑	780.3	Convulsions
❑	❑	❑	780.4	Dizziness
❑	❑	❑	780.2	Fainting
❑	❑	❑	780.7	Fatigue
❑	❑	❑	780.6	Fever
❑	❑	❑	784.0	Headache
❑	❑	❑	780.52	Loss of Sleep
❑	❑	❑	783	Loss of Weight
❑	❑	❑	799.2	Nervousness
❑	❑	❑	729.2	Neuralgia
❑	❑	❑	780.8	Night Sweats
❑	❑	❑	782	Numbness or pain in arms/ legs/ hands
❑	❑	❑	786.09	Wheezing

MUSCLES & JOINTS

Never	Previously	Presently		
❑	❑	❑	724.5	Backache
❑	❑	❑	719.7	Foot Trouble
❑	❑	❑	550.0	Hernia
❑	❑	❑	719.1	Pain Between Shoulders
❑	❑	❑	724.6	Painful Tail Bone
❑	❑	❑	723.9	Stiff Neck
❑	❑	❑	781.9	Spinal Curvature
❑	❑	❑	719.0	Swollen Joints
❑	❑	❑	781.0	Tremors
❑	❑	❑	781.0	Twitching
❑	❑	❑	728.8	Weakness

_____

OPERATIONS AND PROCEDURES

DATE		DATE		DATE	
_____	Vaccinations	_____	Tubes in Ears	_____	Sinus
_____	Tonsillectomy	_____	Appendectomy	_____	Hernia
_____	Gall Bladder	_____	Female Organs	_____	Thyroid
_____	Back Operation	_____	Rectal Surgery	_____	Stomach
_____	Other _____	_____	Other_____	_____	Other _____

❑ I have never had any operations/surgeries.

List any accidents or falls and dates: ❑ Car_____ ❑ Recreational Vehicle _____
❑ Sports_____ ❑ School _____ ❑ Other _____

List any broken bones (fractures) or dislocations : _____

Ever on crutches? ❑ No ❑ Yes Why? _____

Have you ever had any spinal taps or spinal injections? ❑ Yes ❑ No Were you ever knocked unconscious? ❑ Yes ❑ No

Have you ever had a lapse of memory? ❑ Yes ❑ No

Have you ever had X-rays taken? ❑ No ❑ Yes When? _____ By whom? _____

For what ailments were these X-rays made? _____

Do you suffer from any condition other than that for which you are now consulting us? _____

Are you presently taking any medication - prescription or over-the-counter? ❑ No ❑ Yes What drugs? _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's 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 the Doctor's 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.

I hereby authorize the Doctor to examine and treat my condition as he deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed the amount paid the Doctor for X-rays is for examination only and the X-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

Patient's/Guardian's Signature X _____ Date_____