

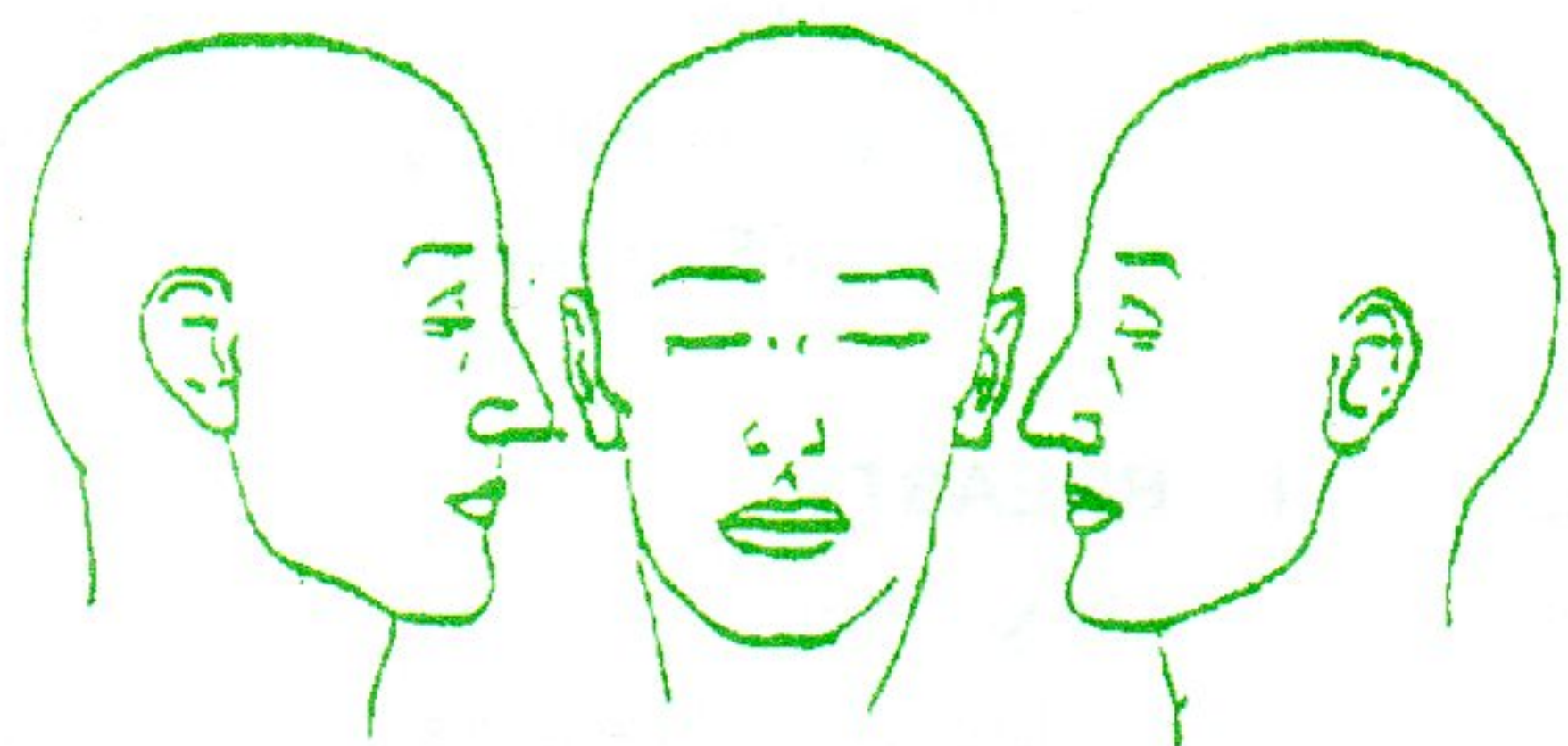
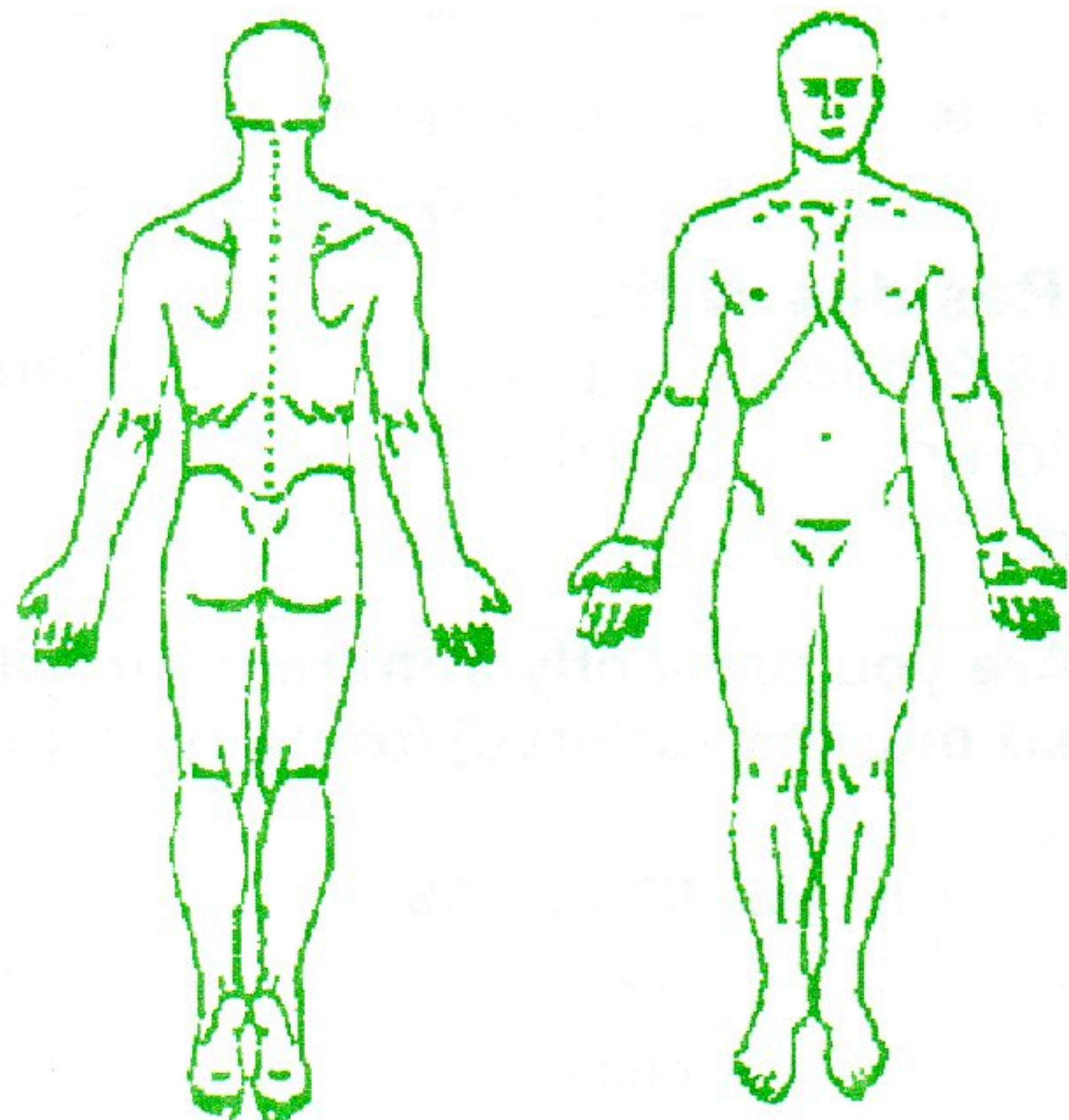
2. What are your habits?

Smoking
Alcohol
Recreational Drugs
Exercise

	Never	Occasionally	Moderately	Excessively
Smoking	(S)	(S)	(S)	(S)
Alcohol	(A)	(A)	(A)	(A)
Recreational Drugs	(R)	(R)	(R)	(R)
Exercise	(E)	(E)	(E)	(E)

C. PAIN DIAGRAMS

Please mark the location of your pain on these figures



D. MEDICAL HISTORY

1. HEALTH CARE

- | | Yes | No |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|-----|
| a. Have you been to a chiropractor | (Y) | (N) |
| b. Do you have a family physician | (Y) | (N) |
| c. WOMEN: | | |
| To the best of your knowledge are you pregnant | (Y) | (N) |
| Are you under the regular care of an OB-GYN ... | (Y) | (N) |
| d. Have you been hospitalized in the past five years | (Y) | (N) |
| e. Are you currently taking any medication | (Y) | (N) |
| <input type="checkbox"/> Anti-inflammatory (Aspirin, Motrin, etc.)
<input type="checkbox"/> Muscle Relaxants <input type="checkbox"/> Pain Medication/Analgesic
<input type="checkbox"/> Tranquilizers <input type="checkbox"/> Birth Control Pills
<input type="checkbox"/> Other | | |

2. Which of the following illnesses have you had?

- No Previous Conditions/Illnesses
- Arthritis
- Asthma
- Sinus Trouble
- Hay Fever
- Allergies
- Tuberculosis
- Diabetes
- Epilepsy
- Thyroid Trouble
- High Blood Pressure
- Low Blood Pressure
- Heart Trouble
- HIV/ARC
- AIDS
- Sexually Transmitted Disease
- Ulcer
- Cancer
- Polio
- Rheumatic Fever
- Serious Injury
- Bone Fracture
- Dislocated Joints
- Spinal Disc Disease
- Multiple Sclerosis
- Scoliosis
- Mental/Emotional Difficulty
- Prostate Trouble
- Kidney Trouble
- Other

3. FAMILY HISTORY

	Cancer	Diabetes	Heart Trouble	High Blood Pressure	Stroke	Multiple Sclerosis	Headaches	Neck Problems	Back Problems	Disc Problems	Joint Problems	Arthritis	Pinched Nerve	Osteoporosis	Scoliosis	Bad Posture
Father	(F)	(F)	(F)	(F)	(F)	(F)	(F)	(F)	(F)	(F)	(F)	(F)	(F)	(F)	(F)	(F)
Mother	(M)	(M)	(M)	(M)	(M)	(M)	(M)	(M)	(M)	(M)	(M)	(M)	(M)	(M)	(M)	(M)
Brothers	(B)	(B)	(B)	(B)	(B)	(B)	(B)	(B)	(B)	(B)	(B)	(B)	(B)	(B)	(B)	(B)
Sisters	(S)	(S)	(S)	(S)	(S)	(S)	(S)	(S)	(S)	(S)	(S)	(S)	(S)	(S)	(S)	(S)
Children	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)	(C)

E. INSURANCE INFORMATION

- | | Yes | No |
|----------------------------------------------------------|-----|-----|
| 1. Is your condition due to an automobile accident | (Y) | (N) |
| Date of Accident | [] | |
| Have You filed an accident report | (Y) | (N) |
| 2. Is your condition due to a job injury | (Y) | (N) |
| Date of Injury | [] | |
| Have You filed an injury report | (Y) | (N) |
| 3. Do you have health insurance | (Y) | (N) |
| Company | [] | |
| Policy # | [] | |
| 4. Are you covered by Medicare | (Y) | (N) |
| Medicare # | [] | |

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this 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 Office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to 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.

F. PAYMENT

I WILL BE PAYING TODAY BY:

- Cash Check Credit Card
 MasterCard Visa American Express

Account # [] Exp. Date []

All accounts not paid within 90 days will automatically be put through on your credit card.

Patient's Signature [] Date []

Guardian or Spouse's Signature [] Date []

Doctor's Signature [] Date []