PLEASE PRINT

What is your major complaint ? _____

_____

Other complaints _____

How long have you had this condition? _____ Have you had this or similar Conditions in the past? _____

What activities aggravate your condition? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Constant ☐ Comes and goes

Is this condition interfering with your: ☐ Work ☐ Sleep ☐ Daily routine Other _____

How long has it been since you really felt good ? _____

What do you believe is wrong with you? _____

Have you been in an auto accident ? ☐ Past year ☐ Past 5 years ☐ Over 5 years ☐ Never

Describe _____

DO YOU:	YES	NO	HABITS	Heavy	Moderate	Light	None
Now take vitamins or minerals ?	☐	☐	Alcohol	☐	☐	☐	☐
Think you may need vitamins or minerals ?	☐	☐	Coffee	☐	☐	☐	☐
Wear orthotics ?	☐	☐	Tobacco	☐	☐	☐	☐
			Exercise	☐	☐	☐	☐

PRIMARY INSURANCE: _____ ID # (AS ON CARD) _____

NAME OF INSURED PARTY

If other than yourself _____ BIRTH DATE: _____

NAME OF INSURANCE CO.: _____ ADDRESS: _____

TELEPHONE # _____ REFERRED BY: _____

SECONDARY (SUPPLEMENTAL) INSURANCE: Y / N NAME of INS CO.: _____

NAME OF INSURED PARTY

If other than yourself _____ BIRTH DATE _____

INSURANCE ID # (as on card): _____

If you are now or recently have been under the care of another Chiropractor or a physician, please tell us what you are being treated for, the type of treatment you receive and/or the names of any drugs you are taking:

_____

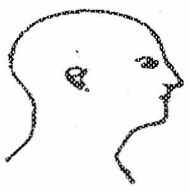
If you have had any surgery, please state type and approximate dates:

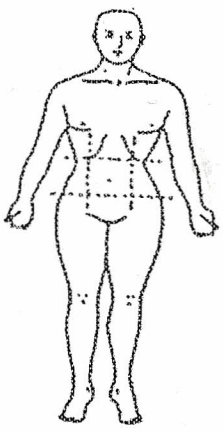
_____

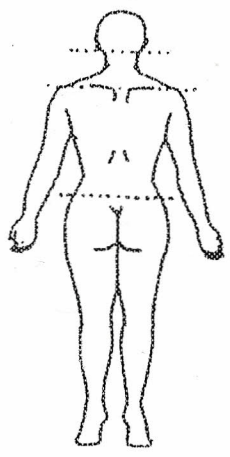
If you had any serious conditions, injuries, and/or fractures please list with approximate dates:

_____

PLEASE MARK ON FIGURES ALL AREAS 0F INVOLVEMEN'I'







I Authorize the release of this information as deemed necessary by my doctor. I Authorize my Chiropractor to be paid directly for covered insurance benefits.

SIGNATURE: _____ DATE _____