Have you ever been treated for any of the following? ______ heart disorder

______ arthritis	______ cancer	______ lung "
______ stroke	______ epilepsy	______ blood "
______ asthma	______ convulsions	______ stomach "
______ allergies	______ alcoholism	______ bowel "
______ diabetes	______ venereal disease	______ bladder "
______ hepatitis	______ AIDS / HIV	______ thyroid "
______ prolonged bleeding		______ kidney "

Have you ever been unconscious? _______ Give reason: ____

Are you troubled by any of the following:

______ headache	______ constipation	______ muscle weakness
______ neck pain	______ nervousness	______ loss of balance
______ back pain	______ excessive fatigue	______ difficulty sleeping
______ stomach pain	______ indigestion	______ difficulty walking
______ chronic cough	______ frequent urination	______ inability to stop stress

Do you: Smoke? Y N Have high blood pressure? Y N Take oral contraceptives? Y N

Are you presently taking any medications? _________ Please list them:

____

____

____

ADDITIONAL INFORMATION: Please list any significant hospitalizations or operations and their dates. If you have any other health concerns please use this space to describe them.

____

____

____

Payment policy: Chiropractic fees are due at the time of service. If the Worker's Compensation Board or a private insurance company fail to reimburse for services rendered the patient then assumes responsibility for payment. I understand and agree to this policy:

Signature: ____

THANK YOU for completing this form. It helps us to care for your health. QUALITY CARE IS OUR GOAL!