Have you been treated by a chiropractor before? Yes _____ No _____
If yes, doctor's name _____ Date of last office visit ____/____/____
Are you under another doctor's care for anything now? Yes _____ No _____
If yes, list the doctor's name and condition: _____
Are you currently taking any over-the-counter or prescription medications? Yes _____ No _____
If yes, please list all, what for, & how long: (Example: Progesterin / Hormone Replacement / 15 years)

_____

Please list any and all surgeries you have had in your lifetime (Whether or not they are related to your back), and what year they were performed

_____

If you answer yes to the following 3 questions, please indicate the month and year in which it occurred.
Have you been in any car accidents (Driver or Passenger)? Yes No When? _____
Have you had any work injuries? Yes No When? _____
Have you had any traumas, like fractures or falls? Yes No When? _____
Is there anyone in your family with: Please list who and if maternal/ paternal side

Cancer?	Yes _____	No _____	_____
Diabetes?	Yes _____	No _____	_____
Heart Disease?	Yes _____	No _____	_____
Arthritis?	Yes _____	No _____	_____
Spinal Problems?	Yes _____	No _____	_____
Scoliosis?	Yes _____	No _____	_____

Diet: On average, how many meals/day do you eat?____ How many servings (1/2 cup) of vegetables ___ per day / week? How much fruit ___ day / week? How much do you drink in ounces per day? H2O _____ Soda _____ (Diet / Regular) Milk _____ Juice _____ Coffee _____ Tea _____ Other _____
Do you smoke? Yes No Do you use other tobacco products? Yes No
Do you consume alcohol? Yes No Do you use recreational drugs? Yes No
How much do you exercise? ___ X Days / Week / Month Cardio Weight/Strength Training Other
On average, how much sleep do you get? Hours/Night Do you sleep straight through? Yes No
Do you feel rested when you awake? Yes No Do you sleep mostly on your: Back ___ Stomach ___ R Side ___ L Side ___? Do you use a special pillow for your neck? Yes No
When was the last time you had a complete physical and/or pap smear? _____/_____/_____
Please indicate any other pertinent medical history information not indicated on this form

_____
_____
_____
_____

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical, personal, or insurance status. I authorize payment from my insurance carrier directly to this office with the understanding that all monies will be credited to my account upon 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, fees for services rendered will immediately be due and payable. In the event I default, I promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of monies owed. I also authorize release of medical information under the same policy.

Patient (Or Authorized) Signature _____ Date ____/____/____
For minor (if applicable) _____
(Print Name)

(Please present your Driver's License and Medicare card if applicable)