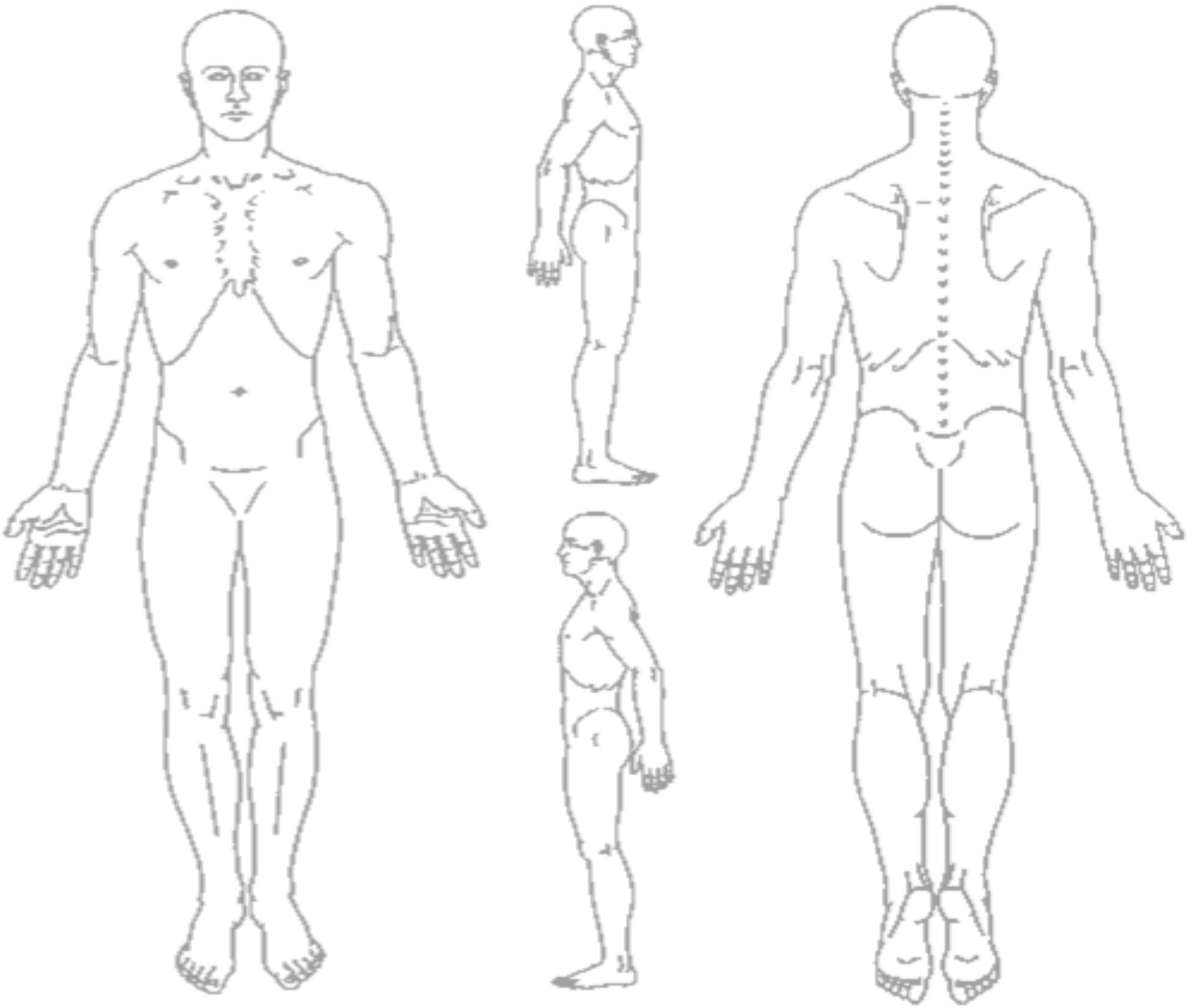
Name: _____ Date: _____

Symptoms Diagram

Please use these letters to mark on the diagram to indicate the type and location of your symptoms, as it relates to the purpose of your visit today.

A = ACHE		G = STABBING		N = NUMBNESS		P = PINS & NEEDLES	
B = BURNING		M = SPASMS		T = TINGLING		F = STIFFNESS	



⚠ Important:

Are any of your current symptoms related to an auto or work injury? ☐ No ☐ Yes If yes, when: _____/_____/_____

If your symptoms are the result of an auto accident or work-related injury, please tell the front-desk person immediately.

Experience With A Chiropractor:

Have you seen a Chiropractor before? ☐ No ☐ Yes Why did you go?:_____

Did your previous Chiropractor take "before" and "after" x-rays? ☐No ☐ Yes

How long were you treated (3-4 times, 3-4 weeks… months?) _____ How did you respond? _____

Last chiropractic treatment date _____/_____/_____

Health History

Name: _____ Date: _____

1. Have you ever had…

☐ Diabetes	☐ Cancer	☐ Epilepsy/Seizures	☐ Metal Implants
☐ Osteoporosis (or penia)	☐ Stroke	☐ Multiple Sclerosis	☐ Thyroid Problems
☐ High Blood Pressure	☐ Heart Disease	☐ Hernia	☐ Infectious Disease
☐ Broken bones/fractures	☐ Arthritis	☐ Migraine Headaches	☐ Tuberculosis

2. Now (or in the last 6 months)…

HEART/LUNGS ☐ Normal

☐ Cough	☐ Blue Extremities
☐ Wheezing	☐ Murmur
☐ Difficulty Breathing	☐ Chest Pain
☐ Swollen Extremities	☐ Palpitations

NEUROLOGIC ☐ Normal

☐ Headache	☐ Fainting
☐ Dizziness	☐ Convulsions

EYES ☐ Normal

	Right	Left
Vision Trouble	☐	☐
Pain	☐	☐
Discharge	☐	☐
Other	☐	☐

DIGESTIVE ☐ Normal

☐ Decreased Appetite	☐ Vomiting
☐ Increased Appetite	☐ Diarrhea
☐ Abdominal Pain	☐ Constipation

3. Please list any medications you are currently taking and for what condition: _____

_____

4. Please list any surgeries…ever (include type of surgery and when it was performed): _____

_____

Authorization of Care

I understand all the information which was provided to me today and guarantee that all 3 pages (Patient Information, Symptom Diagram, Health History) contained in this form were filled out correctly and to the best of my knowledge.

I authorize and agree to allow the doctor and/or his designated staff to work with my spine or the spine of the charge I represent through the use of spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration of normal bio-mechanical and neurological function. I understand that no treatment plan or recommendation is a promise of cure.

I understand that I am responsible for all fees incurred for the services provided, and agree to ensure full payment of all charges.

The Doctor and/or his staff will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another healthcare practitioner, or are not related to the spinal structural conditions diagnosed at this clinic.

I also clearly understand that if I do not follow the doctor's specific recommendations at this clinic that I will not receive the full benefit from these programs; and that if I terminate my care prematurely that all fees incurred will be due and payable at that time.

Patient's Signature: _____ Date: _____/_____/_____

Patient's Name Printed _____

If patient is a legal charge of limited capacity requiring guardianship for treatment, please complete the following:

Date Guardianship Awarded: _____/_____/_____ County, State of Guardianship: _____

I hereby authorize the doctor to administer care as deemed necessary to my charge as appointed to by the courts.

Guardian Signature: _____ Date: _____/_____/_____