

OTHER COMPLAINTS OR COMMENTS: _____

HAVE YOU BEEN TREATED FOR ANY OTHER HEALTH CONDITION IN THE PAST YEAR? YES NO
IF YES, PLEASE DESCRIBE: _____

HAVE YOU BEEN UNDER CHIROPRACTIC CARE BEFORE? YES NO
NAME OF DOCTOR _____ DATE OF LAST ADJUSTMENT _____
RESULTS: _____

ARE YOU CURRENTLY TAKING ANY PRESCRIPTION OR NON-PRESCRIPTION MEDICATION? YES NO
IF YES, PLEASE GIVE NAMES AND FOR WHAT CONDITION: _____

HAVE YOU EVER BEEN IN AN AUTO ACCIDENT OR OTHER SERIOUS INJURIES? YES NO
IF YES, PLEASE DESCRIBE (GIVE DATES AND/OR AGES) _____

HAVE YOU EVER BEEN HOSPITALIZED? YES NO
IF YES, PLEASE DESCRIBE (GIVE DATES AND/OR AGES) _____

HAVE YOU EVER HAD SURGERY? YES NO
IF YES, PLEASE DESCRIBE (GIVE DATES AND/OR AGES) _____

IN CASE OF EMERGENCY CONTACT NEXT OF KIN EXCLUDING SPOUSE. NAME _____
ADDRESS _____ PHONE _____

PLEASE CHECK THE TYPE OF CARE YOU DESIRE SO THAT WE MAY BE GUIDED BY YOUR WISHES WHEN POSSIBLE:

- I PREFER THE DOCTOR TO SELECT THE TYPE OF CARE HE FEELS IS BEST FOR ME
- MAXIMUM IMPROVEMENT
- TEMPORARY RELIEF

I DO HEREBY, THAT ALL OF MY STATEMENTS ON THIS APPLICATION FOR CHIROPRACTIC CARE ARE TRUE, ACCURATE AND COMPLETE.

YOUR SIGNATURE _____ DATE _____