**OTHER COMPLAINTS OR COMMENTS:** ______________________________________________
______________________________________________________________________

**HAVE YOU BEEN TREATED FOR ANY OTHER HEALTH CONDITION IN THE PAST YEAR?** ____________
**IF YES, PLEASE DESCRIBE:** _____________________________________________________
______________________________________________________________________

**HAVE YOU BEEN UNDER CHIROPRACTIC CARE BEFORE?** _________________________________
**IF YES, NAME OF DOCTOR** _______________________ **DATE OF LAST ADJUSTMENT** ___________
**RESULTS:** __________________________________________________________________

**ARE YOU CURRENTLY TAKING ANY PRESCRIPTION OR NON-PRESCRIPTION MEDICATION?** ________
**IF YES, WHICH ONES AND FOR WHAT CONDITION?** ____________________________________
______________________________________________________________________
**DRUG ALLERGIES:** ____________________________________________________________

**HAVE YOU EVER BEEN IN AN AUTO ACCIDENT OR OTHER SERIOUS INJURIES?** __________________
**IF YES, PLEASE DESCRIBE (GIVE DATES AND/OR AGES)** _______________________________
______________________________________________________________________

**HAVE YOU EVER BEEN HOSPITALIZED AND/OR HAD SURGERY?** ____________________________
**IF YES, PLEASE DESCRIBE (GIVE DATES AND/OR AGES)** _______________________________
______________________________________________________________________
______________________________________________________________________

**HAVE YOU EVER EXPERIENCED A BONE FRACTURE?** ___________________________________
**IF YES, PLEASE DESCRIBE (GIVE DATES AND/OR AGES)** _______________________________
______________________________________________________________________
______________________________________________________________________

**IN CASE OF EMERGENCY CONTACT NEXT OF KIN EXCLUDING SPOUSE: PHONE** __________________
**NAME** ______________________________ **ADDRESS** ________________________________

**PLEASE INDICATE 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 CERTIFY THAT ALL OF MY STATEMENTS ON THIS APPLICATION FOR CHIROPRACTIC CARE ARE TRUE, ACCURATE, AND COMPLETE.**

**YOUR SIGNATURE** ____________________________________ **DATE** _________________