GIVE DATE AND CIRCUMSTANCE FOR ANY OF THE FOLLOWING:

Auto Accident	Yes / No	Date: _____	Explain: _____
Surgery	Yes / No	Date: _____	Explain: _____
Job Related Injury	Yes / No	Date: _____	Explain: _____
Serious Fall	Yes / No	Date: _____	Explain: _____
Plastic Surgery (Woman)	Yes / No	Date: _____	Explain: _____

CIRCLE IF PATIENT HAS OR HAS HAD ANY OF THE FOLLOWING PROBLEMS:

Blurred Vision	Concentration Loss	High Blood Pressure	Cancer
Lung Problems	Stomach Problems	Heart Condition	Arthritis
Bladder	Kidneys	Colon	Headaches
Poor Circulation	Sinusitis	Diabetes	Gallbladder
Prostate			

What problems are you taking medication for presently? _____

_____

Do you have a family doctor? _____

Have you had previous chiropractic care? _____

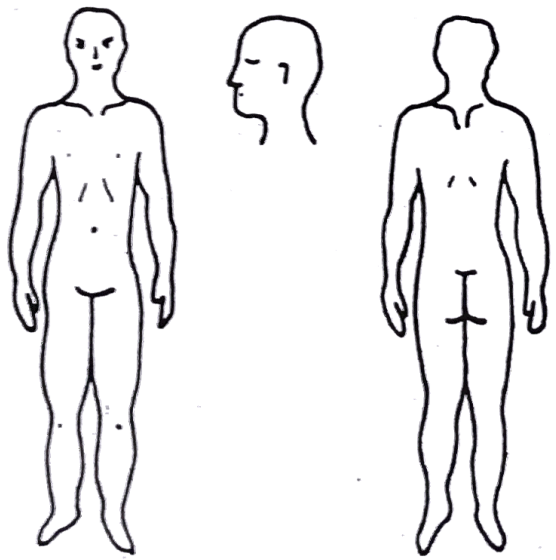
Are you pregnant? _____

FAMILY HISTORY:

Headaches _____
Back Problems _____
Cancer _____
Scoliosis _____
Strokes _____
Heart Attacks _____

Heart Disease _____
High BP _____
Arthritis _____
Indigestion _____
Diabetes _____
Sinusitis _____

Mark areas of complaints below



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Doctors Signature