



# HEALTH HISTORY

Do you have or have you had any of the following diseases, medical conditions or procedure:

|                                |   |                           |                                  |                              |
|--------------------------------|---|---------------------------|----------------------------------|------------------------------|
| Y N Heart<br>Attack/Stroke     | Y N Heart<br>Surgery./Pacemaker         | Y N Artificial<br>Valves  | Y N Congenital Heart<br>Defect   | Y N Mitral Valve<br>Prolapse |
| Y N<br>Emphysema/Asthma        | Y N Arthritis                           | Y N Tuberculosis          | Y N Hepatitis                    | Y N<br>Anemia/Diabetes       |
| Y N Shingles                   | Y N Cancer                              | Y N Frequent<br>Neck Pain | Y N Glaucoma                     | Y N Lower Back<br>Problems   |
| Y N High/Low Blood<br>Pressure | Y N Artificial Bones<br>Joints/Implants | Y N Rheumatic<br>Fever    | Y N Severe/Frequent<br>Headaches | Y N Difficulty<br>Breathing  |
| Y N Ulcers/Colitis             | Y N Kidney<br>Problems                  | Y N Sinus<br>Problems     |                                  |                              |

Please list any surgeries with dates and/or any other serious medical condition(s) not listed above:

\_\_\_\_\_

List any past serious accidents with date: \_\_\_\_\_

Please list anything that you may be allergic to: \_\_\_\_\_

Family Health History: \_\_\_\_\_

Do you take Supplements or Vitamins? Yes No Do you exercise? No Yes \_\_\_\_\_ hours per week

Do you smoke? No Yes How much? \_\_\_\_\_ How Long? \_\_\_\_\_

Are you wearing: Shoe lifts Inner soles Arch supports Are you dieting: No Yes Since \_\_\_\_/\_\_\_\_/\_\_\_\_

For Women: Are you taking Birth Control? Yes No

Are you nursing? Yes No Are you pregnant? Yes No If so, how many weeks? \_\_\_\_\_

- We invite you to discuss with us any questions regarding our services. The best services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges or any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment

## AUTHORIZATION

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the chiropractor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the chiropractor or chiropractic group insurance benefits otherwise payable to me. I understand that my chiropractic insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Adult patient  Parent or Guardian  Spouse