

## **Health History Information:**

Name		Date of Birth				
Address		City/State		Zip		
Mailing Address		City/State		7in		
E-mail Address			Age	_Sex		
Employer		_Occupation				
Marital Status	Spouse's Name		# of childr	en		
Home Ph	WorkPh	Cell P	h			
	ropractic Care before? Yes or					
Whom can be thanked for	referring you?					
When did it first start? On a scale of 1 to 10, RA Is it affecting your daily liv Have you consulted any c Whom:	ppractic care: What do you think IE your PAIN? (1 being the leasting? Yes or No How? ther healthcare providers about t When: auto accident? Yes or No	caused it?		7 8 9 10 -		
List with approximate E Surgeries undergone: Hospitalizations: Bone fractures: Vehicle accidents:	being taken:					
Date of last medical exam	ination:l exam:	Dr.'s Name:				
List any hobbies:	No (type)					
Please add any additional	information that you feel the Doo		t.			
			Over		<u> </u>	

	s tnat apply to you:	
□ Anemia □ Allergies □ Bladder/Bowel problems □ Dizziness □ Hepatitis B or C □ Kidney Disorders □ Neuritis □ Prostate problems □ Stroke/heart disease □ Weightgain/lossproblems	□ Asthma □ Arthritis □ Cancer □ Digestive disorders □ Headaches □ Night sweats □ Nervousness □ Tinitus □ Tuberculosis □ Thyroid condition	□Arm/shoulder problems □Backaches □Diabetes □Eye/Ear problems □High blood pressure □Numbness □Psycological/emotional disorders □Sinus trouble □NONE □Other:
Emergency contact person:		Ph.:
Pain or symptoms are NOT the reason any ailments or conditions you may ha body strives to maintain health, if unab puts pressure on the nerves within the between the brain, nerves and body. Y	is for chiropractic adjustments ve. Alignments of the spine a let o do so, it is suffering from spine. Thus the removal of vou are encouraged to seek of soffice. Chiropractic care is information I've provided is to	, ,
Patient Signature		Date
Doctor's notes:		