ANY FALLS OR ACCIDENTS THAT MAY HAVE CAUSED THIS COMPLAINT? [ ] YES [ ] NO

IF YES, PLEASE CHECK ONE: [ ] AUTO ACCIDENT [ ] HOME ACCIDENT [ ] WORK RELATED

DATE OF ACCIDENT:____

HAVE YOU HAD PREVIOUS CHIROPRACTIC CARE? [ ] YES [ ] NO **IF YES, EXPLAIN**

CONDITION, DATES OF CARE AND DOCTOR'S NAMES: ____________________

____

ON A SCALE OF 1 TO 10 (WITH 1 BEING GOOD AND 10 BEING THE WORST POSSIBLE) PLEASE RATE HOW YOU FEEL RIGHT NOW? ____________________

ON A SCALE OF 1 TO 10 (WITH 1 BEING GOOD AND 10 BEING THE WORST POSSIBLE) PLEASE RATE HOW YOU HAVE BEEN FEELING LATELY? ____________________

Have you, or do you suffer from any of the following? Please check all that apply:

[ ] ALLERGIES
[ ] ANEMIA
[ ] ANKLE/ KNEE SWELLING
[ ] ARTHRITIS
[ ] ASTHMA
[ ] BACK PAIN
[ ] BEDWETTING
[ ] BRONCHITIS
[ ] CANCER
[ ] CHEST PAIN
[ ] CHRONIC COUGH
[ ] COLD FEET
[ ] COLD HANDS
[ ] COLD SWEATS
[ ] CONSTIPATION
[ ] DEPRESSION
[ ] DIABETES
[ ] DIARRHEA
[ ] DIZZINESS
[ ] EAR DISORDERS
[ ] EAR RINGING/ BUZZING
[ ] EPILEPSY
[ ] FACE FLUSHED
[ ] FAINTING
[ ] FATIGUE
[ ] FEVER
[ ] HAY FEVER
[ ] HEADACHES
[ ] HEAD FEELS HEAVY
[ ] HEART PROBLEMS
[ ] ↑ or ↓ BLOOD PRESSURE
[ ] IRRITABILITY
[ ] LEG PAIN/ STIFFNESS
[ ] LIGHT BOTHERS EYES
[ ] LOSS OF BALANCE
[ ] LOSS OF MEMORY
[ ] LOSS OF SMELL
[ ] LOSS OF TASTE
[ ] MAJOR INFECTIONS
[ ] MEASLES/ MUMPS
[ ] MENSTRUAL ISSUES
[ ] NAUSEA
[ ] NECK PAIN
[ ] NECK STIFFNESS
[ ] NERVOUSNESS
[ ] NUMBNESS/ TINGLING IN ARMS
[ ] NUMBNESS/ TINGLING IN LEGS
[ ] PHLEBITIS
[ ] PNEUMONIA
[ ] POLIO
[ ] RECURRENT SORE THROAT
[ ] RHEUMATIC/ SCARLET FEVER
[ ] SHORTNESS OF BREATH
[ ] SHOULDER PAIN
[ ] SINUS PROBLEMS
[ ] SLEEPING PROBLEMS
[ ] STROKE
[ ] TENSION
[ ] TINGLING IN FINGERS
[ ] TINGLING IN TOES
[ ] TUBERCULOSIS
[ ] ULCERS
[ ] UPSET STOMACH
[ ] URINARY DISORDERS
[ ] OTHER
____

A) FOR ASSIGNMENT OF YOUR HEALTH INSURANCE BENEFITS PLEASE SIGN BELOW: **I AM AWARE THAT IF MY INSURANCE COMPANY DOES NOT COVER SERVICES RENDERED IN THIS OFFICE, I AM RESPONSIBLE FOR PAYMENT IN FULL.**

SIGNATURE________________________________ DATE________________

B) **I HEARBY AUTHORIZE DR. PAINTER (CHIROPRACTOR) TO RELEASE, AS HE DEEMS NECESSARY, ANY AND ALL INFORMATION ACQUIRED IN THE COURSE OF EXAMINATION AND TREATMENT TO PROCESS THIS CLAIM.** I HEREBY GIVE PERMISSION TO DR. PAINTER (CHIROPRACTOR) TO ADMINISTER TREATMENT AND PERFORM SUCH PROCEDURES AS HE MAY DEEM NECESSARY IN THE DIAGNOSIS AND/ OR TREATMENT OF MY CONDITION.

SIGNATURE________________________________ DATE________________