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

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________________