

Please check the correct box for each item below. Check at least one box for each sign or symptom listed.  Never  Previously  Presently.

<table border="0"> <tr> <td style="text-align: center;">Never Previously Presently</td> <td><b>GENERAL SYMPTOMS</b></td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></td> <td>995.3 Allergy (What)_____</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></td> <td>490 Bronchitis</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></td> <td>780.9 Chills</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></td> <td>780.39 Convulsions</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></td> <td>780.4 Dizziness</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></td> <td>780.2 Fainting</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></td> <td>780.79 Fatigue</td> </tr> <tr> <td><input 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**OPERATIONS AND PROCEDURES**

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I have never had any operations / surgeries

List any accidents or falls and dates:  Car: \_\_\_\_\_  Recreation: \_\_\_\_\_  
 Sports: \_\_\_\_\_  School: \_\_\_\_\_  Other: \_\_\_\_\_

List any broken bones (fractures) or dislocations: \_\_\_\_\_  
 Ever on crutches?  Yes  No Why? \_\_\_\_\_  
 Have you ever had any spinal taps or spinal injections?  Yes  No Were you ever knocked unconscious?  Yes  No  
 Have you ever had a lapse of memory?  Yes  No  
 Have you ever had X-rays taken?  Yes  No When? \_\_\_\_\_ By Whom? \_\_\_\_\_  
 For what ailments were these X-rays made? \_\_\_\_\_  
 Do you suffer from any condition other than that for which you are now consulting us? \_\_\_\_\_  
 Are you presently taking any medication - prescription or over-the-counter?  Yes  No What drugs? \_\_\_\_\_

I understand and agree that health and accident insurance policies are an arrangement between the insurance company and me. The Doctor's office will prepare reports and forms necessary to assist me in the filing of my claim with the insurance company but cannot guarantee reimbursement from the insurance company. Direct payments made from the insurance company to the Doctor's office will be credited to my account upon receipt and any balances due will be my responsibility. All services rendered to me are my personal responsibility and I agree to make payment for these services to the Doctor's office. I also understand that if I suspend or terminate my care and treatment, any fees for services rendered will be immediately due and payable. Should third party collection become necessary, I agree to pay all fees involved in collection of the account.

I authorize the Doctor to examine and treat my condition as deemed appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. The amount paid to the Doctor's office for X-rays is for the examination only; the X-ray negatives will remain the property of the Doctor's office and will remain on file at the Doctor's office as long as I am a patient. I am the responsible party for payment of any treatment received or incurred on this account. This Doctor provides only chiropractic care and is not responsible for any pre-existing medically diagnosed conditions or for making any medical diagnosis.

Patient's/Guardian's Signature: X \_\_\_\_\_ Date: \_\_\_\_\_