

How did this condition develop? (What caused it? How did it start?) _____

When was the very first time you were aware of this problem? _____

Have you ever had this problem or similar problem before? If yes, please explain: _____

Have you ever received any treatment for this condition? If yes, where and when, and what were your results? _____

Has this problem been getting better, worse, or staying the same? _____

Is there anything you do that makes your condition worse? _____

How has this condition affected your:

- A. Home life? _____
- B. Occupational life? _____
- C. Recreational life? _____
- D. Rest and sleep life? _____

Have you ever been in an automobile accident? ____ Past year ____ Past 5 years ____ Over 5 years ____ Never

ANY ACCIDENTS, FALLS, ETC. THAT MIGHT HAVE CAUSED YOUR PROBLEM? _____

ANY MEDICAL DIAGNOSIS FOR YOUR COMPLAINT? _____

What surgery has been done? _____

Drugs you now take: ____ Nerve Pills ____ Pain Killers ____ Muscle Relaxers ____ Anti-Depressants ____ Tranquilizers ____ Insulin
____ Birth Control ____ Other (please list) _____

ANY CHIROPRACTOR CONSULTED IN THE PAST? Name: _____

Dates consulted: _____ For what problem? _____

**Fees are payable at the time x-rays, examinations, and treatments are received, unless other arrangements are made in advance.
X-rays remain the property of this clinic.**

Patient's signature: _____

Social Security No. _____ **Date:** _____