CURRENT HEALTH CONDITION

Please list in order of severity the purpose for your appointment today:

Condition #1 (most severe) _____Cervical/neck/headaches _____Thoracic/mid back

_____ Lumbar/lower back _____Sacral/Pelvis _____ Arm/hand _____Leg/foot _____ Wellness

Condition #2 _____Cervical/neck/headaches _____Thoracic/mid back

_____ Lumbar/lower back _____Sacral/Pelvis _____ Arm/hand _____Leg/foot _____ Wellness

Condition #3 _____Cervical/neck/headaches _____Thoracic/mid back

_____ Lumbar/lower back _____Sacral/Pelvis _____ Arm/hand _____Leg/foot _____ Wellness

Have you had any of the following for any of the conditions above?

_____ X-Ray _____MRI _____ CT Scan _____Ultrasound Date Taken _____

Have you seen other Doctor's/Therapist for this condition? _____ Yes _____No

if yes, when and describe type of treatment.

_____

Has the condition occurred before? _____ Yes ____No

Is condition _____ Job Related _____ Auto Accident _____ Home Injury _____ Fall ____ Other

If this is Job related or an auto accident please let us know, as we will need more information .

Do you suffer from any other medical conditions other than you are now consulting us?

_____

PAST HEALTH HISTORY

Have you had any surgeries? _____

When? _____

Broken Bones? _____

Have you had Chiropractic Care? _____ Doctor's name and Date of last visit? _____