

PLEASE PRINT

What is your major complaint? _____

Other Complaints _____

What aggravates your condition? _____

Is this condition getting progressively worse? Yes No Constant Comes and goes

Is this condition interfering with your: Work Sleep Daily routine Other _____

List any surgeries you have had and the year they were performed: _____

Drugs you now take: Nerve Pills Pain Killers Muscle relaxers "pep" pills Tranquilizers Birth Control Pills
Other _____

Dental Visits: Every six months Yearly Toothache or emergency only Complete Dentures

Age of mattress: _____ comfortable Uncomfortable Do You use a bed board? _____

Have you been in an auto accident? Past year Past five years Over five years Never

Describe _____

Have you ever had any mental or emotional disorders? Yes No When? _____

Have others in your family had such disorders? Yes No When? _____

FAMILY HEALTH INFORMATION (Many health problems are the result of hereditary spinal weaknesses; thus information about your family members will give us a better picture of your total health)

Name	Relation	Past and Present Health Problems

Have you ever:	Yes	No	Describe Briefly
Been knocked unconscious?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Used a cane, crutch, or other support?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Been treated for a spine or nerve disorder?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Had a fractured bone?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Been Hospitalized for other than surgery?	<input type="checkbox"/>	<input type="checkbox"/>	_____

Do you:	Yes	No	Describe Briefly
Now take vitamins or minerals?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Think you may need vitamins or minerals?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have an allergy to any drug?	<input type="checkbox"/>	<input type="checkbox"/>	_____

Date of Last:	Less than 6 months	6-18 months	Over 18 months	Never
Spinal examination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical examination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood Test	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chest X-ray	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dental X-ray	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urine test	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Habits	Heavy	Moderate	Light	Never	List Below all the conditions for which You have been treated in the past 10 Years
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

In Case of Emergency: (Name of relative or close friend not living with you):

Name _____ Phone _____