

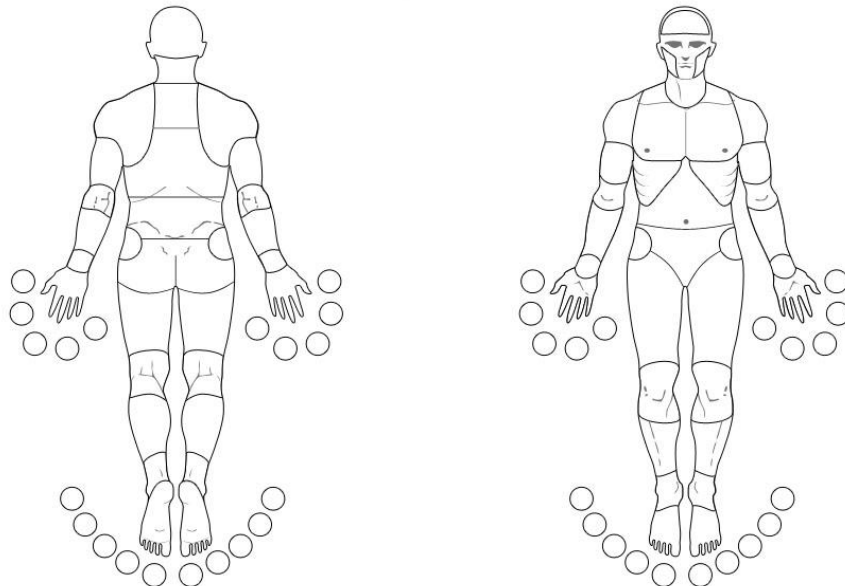
Medical History Information

Date: _____ Ref By: _____

Last Name:		First Name:		Middle Init:	<input type="checkbox"/> Mr.	<input type="checkbox"/> Miss
					<input type="checkbox"/> Mrs.	<input type="checkbox"/> Ms.
<input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Married Spouse's Name: _____						
Email:				Birth date:	Age:	Sex:
Address:			City:	State:	Zip:	
Social Sec. No:		Home Phone:		Cell Phone:		
Occupation:		Employer:		Work No:		
Emergency Contact:			Phone No:	Relationship:		
Have you ever been treated by a chiropractor?:				<input type="checkbox"/> No <input type="checkbox"/> Yes, Name of Doctor: _____		
Are you currently taking any medications?				<input type="checkbox"/> No <input type="checkbox"/> Yes, Please list them: _____		
Have you ever had surgery?: <input type="checkbox"/> No <input type="checkbox"/> Yes, Reason for Surgery and date: _____						
Women Only: (To prevent x-ray exposure) Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you breastfeeding? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Do you have: <input type="checkbox"/> Menstrual cramps <input type="checkbox"/> Menstrual Irregularities						
Present illness / Conditions:						
<input type="checkbox"/> Acid Reflux	<input type="checkbox"/> Cold Hands/Feet/Toes	<input type="checkbox"/> Indigestion	<input type="checkbox"/> Numbness in legs/feet	<input type="checkbox"/> Scoliosis		
<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Kidney trouble	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Shortness of breath		
<input type="checkbox"/> Allergies	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Liver	<input type="checkbox"/> Pain in legs/feet	<input type="checkbox"/> Sinus trouble		
<input type="checkbox"/> Anemia	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Loss of Balance	<input type="checkbox"/> Pins & needles in hands/arms/legs/feet	<input type="checkbox"/> Spinal Disc Disease		
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Herniated Disk	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Prostate trouble	<input type="checkbox"/> Spinal Fracture		
<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart Problem(s)	<input type="checkbox"/> Mental/ Emotional Difficulty	<input type="checkbox"/> Ringing in ears	<input type="checkbox"/> Stomach ache		
<input type="checkbox"/> Bone fracture	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Sensitivity to light	<input type="checkbox"/> Thyroid trouble		
<input type="checkbox"/> Cancer	<input type="checkbox"/> HIV/ARC	<input type="checkbox"/> Numbness in arm/legs	<input type="checkbox"/> Sciatica	<input type="checkbox"/> Twitching of face		

Please indicate the current complaints you are experiencing by circling from 1-25 and marking the areas on the image below.

1. headaches
2. Neck
3. Upper back
4. Mid Back
5. Lower Back
6. Hip
7. Buttock
8. Shoulder
9. Arm
10. Elbow
11. Forearm
12. Wrist
13. Hand
14. Fingers
15. Leg
16. Knee
17. Calf
18. Shin
19. Ankle
20. Foot
21. Toes
22. Chest
23. Ribs
24. Abdomen
25. Pelvis/Groin



- I hereby authorize the doctors and staff of Warner Family Chiropractic to administer any treatments and testing necessary for the purpose of improving my physical condition, and authorize the release of any treatment or account information pertinent to my case to any insurance company, adjuster or attorney involved in this case.
- I agree to provide Warner Family Chiropractic with updates regarding the status of my case and agree to provide notification of changes in insurance information, my personal contact information (address, phone numbers), attorney representation, and settlement agreements.
- I agree that my account with Warner Family Chiropractic is my responsibility and I agree to satisfy any balance that has gone unpaid over 60 days. If I default on my account, I agree to pay all costs of collection, including collection agency fees, late fees, interest, and/or reasonable attorney fees.
- I understand that if I discontinue care in this office without the doctor's consent, I will be immediately responsible for the full amount of my balance.

Patient Name

Date

Patient or Legal Guardian Signature