Please check the correct box for each sign or symptom below.

Previously	Presently	**General Symptoms**
		Allergy (What):_____
		Bronchitis
		Convulsions
		Headaches
		Loss of sleep
		Drastic weight loss
		Night Sweats
		Numbness/pain in arms/legs
		Difficulty Breathing

Previously	Presently	**Muscles & Joints**
		Backache
		Foot Trouble
		Hernia
		Spinal Curvature
		Swollen Joints

Previously	Presently	**Gastro-intestinal**
		Colon Trouble
		Constipation/Diarrhea
		Hemorrhoids
		Liver trouble
		Poor Digestion
		Vomiting Blood

Previously	Presently	**Cardio-Vascular**
		High Blood Pressure
		Low Blood Pressure
		Pain over heart
		Poor Circulation
		Previous Heart Trouble
		Strokes
		Swelling Ankles

Previously	Presently	**Eye/ear/nose/throat**
		Asthma
		Enlarged Thyroid
		Frequent Colds
		Hay Fever
		Sinusitis

Previously	Presently	**Skin or Allergies**
		Boils
		Eczema
		Hives/allergy
		Skin Eruptions

Previously	Presently	**Respiratory**
		Chest Pain
		Chronic Cough

Previously	Presently	**Genito-Urinary**
		Blood in Urine
		Frequent Urination
		Inability or Control Urine
		Kidney Infection
		Painful Urination
		Prostate Trouble

		For Women Only
		Excessive Flow
		Hot Flashes
		Irregular Cycle
		Miscarriage
		Vaginal Discharge
Yes	No	Pregnant at this time
		Last Pap Date:_____
		By Whom:_____

I understand and agree that insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the doctors office will prepare any necessary reports and forms to assist me in making the collection from the insurance company and that any amount authorized to be paid directly to the doctors office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payments. I also understand that if I suspend or terminate my care and treatment any fees or professional services rendered me will be immediately due and payable.

I hereby authorize the doctor to examine and treat my conditions as he deems appropriate through the use of chiropractic, acupuncture, physiotherapy, to include ultrasound, electrotherapy, rehabilitation, heat, ice massage, and/ or traction, and I give authority for these procedures to be performed. Occasionally, a condition will get worse before it gets better. If you do not show improvement, or your symptoms persist or worsen, this could be the sign of a serious condition please notify the doctor. With Chiropractic Manipulation, Acupuncture, Physiotherapy, and Rehabilitation, there are no guarantees implied or extended to me by the doctor in regards to my condition. My condition may require the use of orthotic supports, nutritional or herbal supplementation. If you experience side effects stop taking the formula and notify the doctor immediately. With my signature below, I acknowledge the above statements and agree to hold the doctor harmless, and indemnify him from any claim that may arise out of this, or any treatment. If I am a minor, my parent or acting guardian has read and understands the above items, and his/ her signature below attests to this fact.

Patient's/ Guardian's Signature: _____ Date: _____