



Work and Family History	
Your occupation: _____	Work duties: _____
Is most of your day spent: <input type="checkbox"/> sitting <input type="checkbox"/> standing <input type="checkbox"/> walking <input type="checkbox"/> other (specify) _____	
Spouse's health status: _____	
Children's health status: _____	
Past or present health problems of parents and siblings: _____	
Chiropractic History	
Have you ever been to a chiropractor before? <input type="checkbox"/> Yes <input type="checkbox"/> No Date of last chiropractic visit: _____	
Reason for care: How long were you under care? _____	
Are other family members under chiropractic care? <input type="checkbox"/> Yes <input type="checkbox"/> No With whom? _____	
Wellness Commitment	
We are dedicated toward achieving the goal of total lasting health for all of our patients. To better understand your individual health objectives, please check all that apply that are closest to your personal health goal(s):	
<input type="checkbox"/> Symptom Relief <input type="checkbox"/> Restore Health <input type="checkbox"/> Wellness and Prevention <input type="checkbox"/> Improved Performance	

If you have had the following, or if you suffer from any of the following, please check:

Clinical Symptom or Problem	Constant/ Frequent	Sometimes/ Occasional
Headaches, migraines		
Dizziness		
Fainting, seizures		
Insomnia		
Earaches, hearing problems		
Neck pain		
Shoulder, arm, hand pain		
Numbness, tingling in arms		
High, low blood pressure		
Frequent colds		
Asthma, difficulty breathing		
Sinus problems		
Upper-back pain		
Heart problems		
Mid-back pain		
Digestive problems		
Hip pain		
Leg, foot pain		
Numbness/tingling in legs		
Low-back pain		
Arthritis, joint pain		
Female problems		
Male problems		
Cancer		
Osteoporosis		
Urinary problems		
Skin conditions		
Other (please specify):		

I do hereby authorize the care that is necessary for my particular case. I further agree to pay for services rendered as the charge is incurred. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself, and that I am personally responsible for payment of any and all services covered or non-covered. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's signature (or parent/guardian)

Date