

**PLEASE PRINT**

What is your major complaint? \_\_\_\_\_

Other complaints \_\_\_\_\_

How long have you had this condition? \_\_\_\_\_ Have you had this or similar conditions in the past? \_\_\_\_\_

What activities aggravate 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 \_\_\_\_\_

How long has it been since you really felt good? \_\_\_\_\_

List previous diagnoses and treatments you have received for present condition \_\_\_\_\_

What do you believe is wrong with you? \_\_\_\_\_

List surgical operations and years: \_\_\_\_\_

Drugs you now take:  Nerve pills  Pain killers  Muscle relaxers  "Pep" pills  Tranquilizers  Birth control pills

Others \_\_\_\_\_

Dental visits:  Every six months  Yearly  Toothache or emergency only  Complete dentures

Age of mattress \_\_\_\_\_  Comfortable  Uncomfortable Do you use a bed board: \_\_\_\_\_

Are you wearing:  Heel lifts  Sole lifts  Inner soles  Arch supports

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 picture.)

NAME	RELATION	PAST AND PRESENT HEALTH PROBLEMS

<b>HAVE YOU EVER:</b>	<b>YES</b>	<b>NO</b>	<b>DESCRIBE BRIEFLY</b>
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"/>	_____

<b>DO YOU:</b>	<b>YES</b>	<b>NO</b>	<b>DESCRIBE BRIEFLY</b>
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"/>	_____

<b>DATE OF LAST:</b>	<b>Less than 6 months</b>	<b>6-18 months</b>	<b>Over 18 months</b>	<b>Never</b>
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"/>
Spinal 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"/>

<b>HABITS</b>	<b>Heavy</b>	<b>Moderate</b>	<b>Light</b>	<b>None</b>	<b>LIST BELOW ALL CONDITIONS FOR WHICH YOU HAVE BEEN TREATED IN THE PAST 10 YEARS.</b>
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 in your home):

NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_