GENERAL INFORMATION

Name ..... Date .....

Occupation ..... DOB .....

Email .....

Address ..... City ..... State ..... ZIP Code .....

Phone //
Home ..... Work ..... Cell .....

Emergency Contact //
Name ..... Phone .....

Referred by .....

HEALTH HISTORY

Have you ever received treatment on or been treated for any of the following?

	Y	N		Y	N		Y	N		Y	N		Y	N
Dizziness	☐	☐	Eyes	☐	☐	Headaches	☐	☐	Nervousness	☐	☐	Fractures	☐	☐
Heart Problems	☐	☐	Metabolic	☐	☐	Respiratory	☐	☐	Skin	☐	☐	Sprains	☐	☐
Diabetes	☐	☐	Autoimmune	☐	☐	Allergies	☐	☐	Addiction	☐	☐	Injuries	☐	☐
Hernia	☐	☐	Arthritis	☐	☐	Digestive	☐	☐	Cancer	☐	☐			

List any other medical conditions not covered above: .....

.....

List and date **all** previous surgeries: ..... Medications/Supplements: .....

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Purpose of todays examination: .....

☐ **CHECK HERE IF ADDITIONAL SPACE IS NEEDED**. Please indicate on a separate sheet and attach.