CONFIDENTIAL PATIENT HISTORY

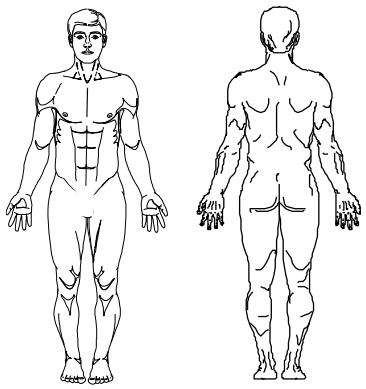
Name _____ Date_____
Address_____ City_____ State_____ ZIP_____
Phone (Home or Cell)_____ Date of Birth_____ Age_____
E-mail address_____ Marital Status S M D W Number of Children____
Occupation_____ Employer_____ Years there___
Spouse's Name_____ Occupation_____
How did you hear about our office?_____
Are you covered by **Medicare?** Y N **State Insurance Aid?** Y N **Group Health Insurance?** Y N

What is your major complaint?_____
How long have you had this?_____ Have you had this before? **Y N** Have you missed work? **Y N**
What activities aggravate your condition?_____
What treatments have you done in the past for this?_____
How long since you really felt good?_____
Any other complaints:_____

Have you had food sensitivities checked? **Y N** Have you done any emotional or energy healing work? **Y N**
Have you ever tried homeopathy? **Y N** Have you ever been tested for heavy metals or toxins? **Y N**
Are you open to learning about a new technique called Holographic Manipulation Therapy? **Y N**
If one of the above techniques could help would you be interested in learning more about them? **Y N**

List date and type of surgeries or hospitalizations_____
Smoking Status: [ ] Never Smoker [ ] Former Smoker [ ]Current-Sometimes Smoker [ ] Current-Everyday Smoker
Are you pregnant or might be? **Y N** Are you currently taking any medication? **Y N**
What med and for what condition?_____
What non-prescription drugs, vitamins or supplements are you taking?_____
_____
Other doctors seen for this condition_____
Family doctor_____ Practice Name/Location _____/_____
Have you ever seen a Chiropractor? **Y N** Who?_____ For what?_____
Date of last visit to a Chiropractor_____ Do you have a pacemaker? **Y N**
Now or in the past any type of: Cancer? **Y N** Infection? **Y N** Stroke? **Y N** Heart Disease? **Y N** Seizures? **Y N**
Spinal Bone Fracture? **Y N**

Please use the pictures below and mark your problem areas with an X.



All of the above information is true and correct. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment for any reason, any fees for professional services rendered to me will be immediately due and payable.

Patient's Signature _____ **Date** _____

Circle All Current Problems You Have

DIZZINESS	**MIGRAINES**	**MENSTRUAL DISORDERS**	**NUMBNESS IN LEGS**	**LUPUS**
HEADACHES	**ANXIETY**	**HEART DISORDERS**	**NUMBNESS IN FEET**	**FIBROMYALGIA**
VERTIGO	**THROAT ISSUES**	**STOMACH DISORDERS**	**LOW BACK PAIN**	**CHEST PAIN**
EAR INFECTIONS	**THYROID PROBLEMS**	**KIDNEY PROBLEMS**	**HIP PAIN OR LEG PAIN**	**ARM PAIN**
NAUSEA	**ASTHMA**	**BLADDER PROBLEMS**	**SHOULDER PAIN**	**ADD/ADHD**
TMJ	**ULCERS**	**IRRITABLE BOWEL/CHROHNS**	**LIVER DISEASE**	**DIABETES**
EPILEPSY	**DISC PROBLEM**	**INFERTILITY**	**GASTRIC REFLUX**	**MID BACK PAIN**
NECK PAIN	**NUMBNESS IN HANDS**	**CHRONIC FATIGUE**	**SCOLIOSIS**	**CHRONIC SINUS ISSUES**

OTHER:_____