

Do you use alcoholic beverages? () yes () no

() light (<=1 drink/day) () moderate (2-3 drinks/day) () heavy (>3 drinks /day).

Age of Mattress: _____ yrs. () comfortable () uncomfortable.

Do you wear () heel lifts () sole lifts () orthotics.

Are you pregnant () yes () no My most recent menstrual period began on _____.

Have you been in an auto accident? () past year () past 5 yrs () over 4 yrs () never. Please Describe:

List all operations and Dates:

Please "X" below if you have suffered from:

- | | | | |
|---|--|--|--------------------------------------|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Muscular Dystrophy | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Convulsions |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Digestive Disorders | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Concussion | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Neuritis | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Backaches | <input type="checkbox"/> German Measles | <input type="checkbox"/> Anemia | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Grip Strength Loss | |

Insurance Data

Is your condition due to an automobile accident? ___ yes ___ no. An accident at work? ___ yes ___ no.

Do you have health insurance? ___ yes ___ no

Insurance company name _____ Your policy number _____

Your ID number _____

Spouse's insurance _____ Policy number _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Comfort Chiropractic will prepare any necessary reports and forms to assist me in making collection from my primary insurance company and that any amount authorized to be paid directly to Comfort Chiropractic will be credited to my account upon receipt. However, I clearly understand and agree that if I suspend or terminate my care and treatment in this office, any fees for professional services rendered me will be immediately due and payable. All overdue accounts will be assessed a service charge of 1.5% per month and will also be liable for all legal and collection fees

I will be paying today by: ___ Cash ___ Check ___ Visa ___ Master Card ___ Discover Card.

Patient's signature: _____ Date: _____

Guardians' or Spouse Signature: _____ Date: _____

Family Health Information

Many health problems are the result of hereditary spinal weakness: thus, information about your family will give us a better picture of your total health picture.

NAME	RELATION	HEALTH PROBLEM