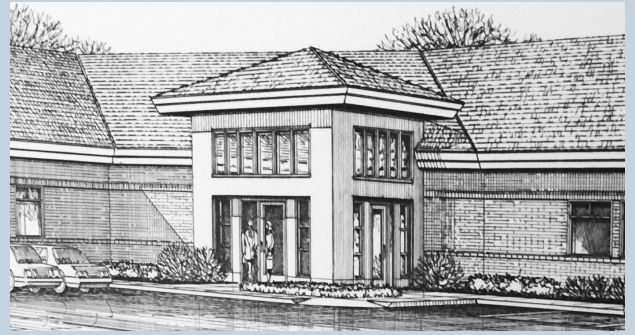




**IN EMERGENCY**

Who should we contact? \_\_\_\_\_  
Relation? \_\_\_\_\_  
Home Phone ( ) \_\_\_\_\_  
Work Phone ( ) \_\_\_\_\_  
Who is your medical doctor? \_\_\_\_\_  
Phone ( ) \_\_\_\_\_



**HEALTH HISTORY**

Are you taking any of the following medications?  Pain Medication (including aspirin)  Muscle Relaxers  
 Stimulants  Blood Thinners  Tranquilizers  Insulin  Other \_\_\_\_\_

Do you have or ever had any of the following diseases or conditions?

- |  |                                    |                                  |                                      |
|--|------------------------------------|----------------------------------|--------------------------------------|
| <b>Y N</b> Heart Attack/Stroke   | <b>Y N</b> Heart Surg/Pacemaker    | <b>Y N</b> Heart Murmur          | <b>Y N</b> Congenital Heart Defect   |
| <b>Y N</b> Mitral Valve Prolapse   | <b>Y N</b> Artificial Valves       | <b>Y N</b> Alcohol/Drug Abuse    | <b>Y N</b> Venereal Disease          |
| <b>Y N</b> Hepatitis   | <b>Y N</b> HIV+/Aids               | <b>Y N</b> Shingles              | <b>Y N</b> Cancer                    |
| <b>Y N</b> Chemotherapy  | <b>Y N</b> Frequent Neck Pain      | <b>Y N</b> Emphysema/Glaucoma    | <b>Y N</b> Anemia                    |
| <b>Y N</b> Psychiatric Problems  | <b>Y N</b> Rheumatic Fever         | <b>Y N</b> Diabetes/Tuberculosis | <b>Y N</b> Difficulty Breathing      |
| <b>Y N</b> Kidney Problems   | <b>Y N</b> Ulcers/Colitis          | <b>Y N</b> Sinus Problems        | <b>Y N</b> Asthma                    |
| <b>Y N</b> Lower Back Problems   | <b>Y N</b> Artificial Bones/Joints | <b>Y N</b> Arthritis             | <b>Y N</b> Severe/Frequent Headaches |
| <b>Y N</b> High/Low Blood Pressure <b>Y N</b> Fainting/Seizures/Epilepsy |                                    |                                  |                                      |

Please list any other serious medical condition(s) you have or ever had \_\_\_\_\_

Please list anything you may be allergic to \_\_\_\_\_

List previous surgeries/treatments with dates \_\_\_\_\_

List any **past** serious accidents with dates \_\_\_\_\_

Family Health History \_\_\_\_\_

Do you take any supplements or vitamins?  Yes  No Do you exercise?  Yes  No

Are you on a special diet?  Yes  No Since? \_\_\_\_\_

Do you smoke?  Yes  No How much? \_\_\_\_\_ How long? \_\_\_\_\_

Are you wearing arch supports  Yes  No

What is the age of your mattress? \_\_\_\_\_ Is it comfortable?  Yes  No

Do you use a conventional pillow? \_\_\_\_\_ Is it comfortable?  Yes  No

For Women: Are you taking birth control?  Yes  No Are you pregnant?  Yes  No How long? \_\_\_\_\_ Are you nursing?  Yes  No

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid in 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and or managed care organization to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.
- I acknowledge that HIPPA policies were available to me to review during the admission process at Schadow Chiropractic.

**SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_