

KAPSNER CHIROPRACTIC CENTERS
Current Health Conditions

Name: _____

Health Condition you are being seen for today: _____

Other Doctors Seen For This Condition? ? Yes ? No Who? _____

Type of Treatment: _____ Results: _____

When Did This Condition Begin? _____

Has This Condition Occurred Before? ? Yes ? No

Is Condition: ? Job Related ? Auto Accident ? Home Injury ? Fall ? Other : _____

Date of Accident: _____ Time of Accident: _____

Drugs You Now Take: ? Nerve Pills ? Pain Killers/Muscle Relaxers ? Blood Pressure Medicine

? Insulin ? Other: _____

Do You Wear A Shoe Lift? ? Yes ? No

Do You Suffer From Any Condition Other Than That Which You Are Now Consulting Us? _____

PAST HEALTH HISTORY

Major Surgery/Operations: ? Appendectomy ? Tonsillectomy ? Gallbladder ? Hernia

? Back Surgery ? Broken Bones ? Other: _____

Major Accident or Falls: _____

Hospitalization (Other Than Above): _____

Previous Chiropractic Care: ? None ? Doctor's Name: _____

Approximate Date of Last Visit: _____

MEDICAL HISTORY

(If any of the following are relevant to your medical history, please check the accompanying box.)

- | | | |
|--|---|--|
| <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"/> Tuberculosis | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Concussion | <input type="checkbox"/> Digestive Disorders |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Backaches |
| <input type="checkbox"/> German Measles | <input type="checkbox"/> Neuritis | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Anemia |

Most patients that come to our office have one of two objectives in mind concerning their health care. Some patients come for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). Your Doctor will weigh your needs and desires when recommending your treatment program.

Please check the type of care desired so that we may be guided by your wishes whenever possible.

? Relief Care ? Corrective Care ? Check here if you want the Doctor to select the type of care appropriate for your condition.

Date

Patient's Signature