Patient Name: ____________________
List surgical operations & years: ____________________
____
Medications (prescription & over the counter) you now take: __nerve pills __pain killers
__muscle relaxers __"pep" pills __tranquilizers __birth control __blood pressure
__others:____________________
Dental visits: __every 6 months __yearly __toothache or emergency only __complete dentures
Age of mattress _____ __comfortable __uncomfortable, Do you use a bed board? __yes __no
Sleeping posture: __side __stomach __back
Are you wearing: __heel lifts __sole lifts __inner soles __arch supports
Have you been in an auto accident: __past year __past 5 years __over 5 years __never
Describe:____________________
List any hobby / sports injuries: ____________________
Have you ever had any mental or emotional disorders? __yes __no When?____________________
Have others in your family had such disorders? __yes __no When?____________________

FAMILY HEALTH INFORMATION: (Many health problems are the result of hereditary spinal weaknesses; thus information about your family members will give us a better picture of your total health. Please include conditions such as heart disease, arthritis, cancer, diabetes, etc.).

NAME	RELATION	PAST & PRESENT HEALTH PROBLEMS

HAVE YOU EVER:	**YES**	**NO**	**DESCRIBE**
Been knocked unconscious?	☐	☐	
Used a cane, crutch, or other support	☐	☐	
Been treated for a spine or nerve disorder	☐	☐	
Had a fractured bone	☐	☐	
Been hospitalized other than surgery	☐	☐	

DO YOU:	**YES**	**NO**	**DESCRIBE**
Now take vitamins or minerals	☐	☐	
Think you may need vitamins/minerals	☐	☐	
Have an allergy to any drug	☐	☐	

DATE OF LAST:	**0-6 months**	**6-18 mo.**	**over 18 mo.**	**never**
Spinal examination	☐	☐	☐	☐
Physical examination	☐	☐	☐	☐
Blood test	☐	☐	☐	☐
Chest X-ray	☐	☐	☐	☐
Spinal X-ray	☐	☐	☐	☐
Dental X-ray	☐	☐	☐	☐
Urine test	☐	☐	☐	☐

HABITS:	**HEAVY**	**MOD.**	**LIGHT**	**NONE**
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tea	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐
White sugar	☐	☐	☐	☐
Physical stress	☐	☐	☐	☐
Mental stress	☐	☐	☐	☐

List all conditions for which you have been treated in the last 10 years.
____

IN CASE OF EMERGENCY: (Name of relative or close friend):
Name:____________________
Address: ____________________ Phone: ____________________