

HEALTH HISTORY

Have you ever experienced any of the following (*please check all that apply*)?

- | | | | | |
|--|---|--|---|---|
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Vertigo | <input type="checkbox"/> Migraines | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Allergies | <input type="checkbox"/> Recurrent Colds | <input type="checkbox"/> Vision Problems | <input type="checkbox"/> Speech Problems |
| <input type="checkbox"/> Head/Scalp Pain | <input type="checkbox"/> Face Pain | <input type="checkbox"/> Face Numbness | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> TMJ |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Hand/Finger Pain | <input type="checkbox"/> Hand/Finger Numbness |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Asthma | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Kidney Problems |
| <input type="checkbox"/> Thyroid Disorders | <input type="checkbox"/> Menstrual Problems | <input type="checkbox"/> Bowel Problems | <input type="checkbox"/> Bladder Problems | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Hip Pain | <input type="checkbox"/> Knee Pain | <input type="checkbox"/> Ankle Pain | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Depression | <input type="checkbox"/> Cancer |

Please complete if you are taking any medications:

Medication	What is the purpose of the medication?	How long have you been taking this?

What do you expect to gain from chiropractic care? _____

Are you most interested in: _____ Correction of the Problem (Fix Care) _____ Relief Only (Patch Care)

If you chose Correction above, please rate your level of commitment (0 – least, 10 – most): _____ / 10

Do you smoke? Y N **Do you feel you eat properly?** Y N **Do you sleep well at night?** Y N

How many 8 oz. cups of water do you drink on a daily basis? 1 – 3 4 – 6 7 – 10 > 10

How important is your health to you? Whatever Somewhat, I don't have time Very Important

FINANCIAL / INSURANCE POLICY

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that ChiroWorks, LLC will process any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to ChiroWorks will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment.

Signature _____ Date _____

Are you here as a result of a work-related injury? Y N	Have you reported it to your employer? Y N
Are you here as a result of a motor vehicle accident? Y N	If yes, please provide the following information:
Your auto insurance company: _____	Agent's name: _____
Policy # _____	Claim # _____
Agent's phone # _____	

AUTHORIZATION TO RELEASE INFORMATION

To: Dr. Douglas Stranko

You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered by you, and I hereby release you of any consequence thereof.

Signature _____ Date _____