

Date of Onset / Injury / Accident _____ Estimated

Please state current problem(s): _____

Are you currently being treated by:

Another Therapist	_____ Yes	_____ No	Or within the last 12 months	_____ Yes	_____ No
Chiropractor / Osteopath	_____ Yes	_____ No	Or within the last 12 months	_____ Yes	_____ No
Home Health Agency	_____ Yes	_____ No	Or within the last 12 months	_____ Yes	_____ No

Major surgeries since birth: _____

Allergies: _____

List current medications: _____

Check if you currently have or previously had any of the following:

- | | |
|---|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Circulation Problems | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Other Illnesses |
| specify: _____ | specify: _____ |
| _____ | _____ |
| _____ | _____ |

The above information is true and accurate to the best of my knowledge. I hereby authorize the release of any medical information necessary for processing insurance claims and payment of medical benefits for myself or the party who accepts assignment of benefits.

Signature _____ **Date** _____