

Health Checklist:

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|-----------------------------------------------|-------------------------------------------------|---------------------------------------------------|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Cancer | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Cold Extremities | <input type="checkbox"/> Constipation | <input type="checkbox"/> Cramps |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Digestion Problems |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Excessive Menstruation | <input type="checkbox"/> Eye Pain or Difficulties |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Headache |
| <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Hot Flashes |
| <input type="checkbox"/> Irregular Heart Beat | <input type="checkbox"/> Irregular Menstrual | <input type="checkbox"/> Kidney Infection |
| <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Loss of Taste | <input type="checkbox"/> Nosebleeds |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Polio | <input type="checkbox"/> Poor Posture |
| <input type="checkbox"/> Prostate Trouble | <input type="checkbox"/> Sciatica | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sinus Infection | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Spinal Curvatures | <input type="checkbox"/> Stroke | <input type="checkbox"/> Swelling of Ankles |
| <input type="checkbox"/> Swollen Joints | <input type="checkbox"/> Thyroid Condition | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Varicose Veins | |

I certify that I'm the patient or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office of chiropractic. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

Signature _____

Date: _____