

Below is a list of conditions which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can effect your overall diagnosis, treatment plan and possibility of being accepted for care.

Please check the conditions you now suffer from or in the past have suffered from:

- | | | | | |
|--|---------------------------------------|--|---|--|
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Malaria | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Venereal Infection | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Anemia | <input type="checkbox"/> Cancer | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Typhoid Fever | <input type="checkbox"/> Measles | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Mental Disorder |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Mumps | <input type="checkbox"/> Goiter | <input type="checkbox"/> Lumbago | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Small Pox | <input type="checkbox"/> Influenza | <input type="checkbox"/> Pleurisy | | |

MUSCULO-SKELETAL

- | | |
|--|---|
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Joint Pain/Stiffness |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Walking Problems |
| <input type="checkbox"/> Arm Pain | <input type="checkbox"/> Difficult Chewing |
| | <input type="checkbox"/> Clicking Jaw |

FEMALES ONLY: When was your last period? _____
 Are you pregnant? Yes No Maybe

NERVOUS SYSTEM

- Numbness
- Paralysis
- Dizziness
- Forgetfulness
- Confusion/Depression
- Fainting
- Convulsions
- Cold/Tingling Extremities

GENITO-URINARY

- Bladder Trouble
- Painful/Excessive Urination
- Discolored Urine

C-V-R

- Chest Pain
- Short Breath
- Blood Pressure Problems
- Irregular Heartbeat
- Heart Problems
- Lung Problems/Congestion
- Vericose Veins
- Ankle Swelling

GENERAL

- Allergies
- Loss of Sleep
- Fever
- Headaches

GASTRO-INTESTINAL

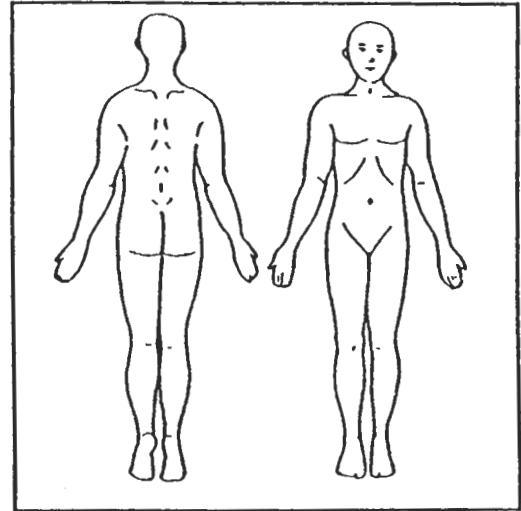
- Poor/Excessive Appetite
- Excessive Thirst
- Frequent Nausea
- Vomiting
- Diarrhea
- Constipation
- Hemorrhoids
- Liver Trouble
- Gall Bladder Problems
- Weight Trouble
- Abdominal Cramps
- Gas/Bloating After Meals
- Pain Between Shoulders
- Black/Bloody Stool
- Colitis

EENT

- Vision Problems
- Dental Problems
- Sore Throat
- Ear Aches
- Hearing Difficulty
- Stuffed Nose

MALE/FEMALE

- Menstrual Irregularity
- Menstrual Cramping
- Vaginal Pain/Infections
- Breast Pain/Lumps
- Prostate/Sexual Dysfunction
- Genital Herpes



Shade area(s) to indicate location of pain or discomfort.

Name of Group/Individual Health Insurance _____

Name of Insured _____ Policy/Group No. _____

Claims Address _____

Name of Spouse's Group/Individual Health Insurance _____

Name of Insured _____ Policy/Group No. _____

Claims Address _____

If you do not have Health Insurance, please indicate responsible party:

Name _____ Relationship _____ Phone () _____

Address _____

PAYMENT IS EXPECTED AT TIME OF VISIT

I understand and agree that Health and Accident Insurance policies are an arrangement between the insurance carrier and myself. Furthermore, I understand that the Schillinger Chiropractic Group will prepare necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to Schillinger Chiropractic Group will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

I will be paying for today's services by: Cash Check Visa/MC

Signature _____ Today's Date _____