



Has this condition caused you loss of normal activities?

- A. Home \_\_\_\_\_
- B. Occupation: \_\_\_\_\_
- C. Recreation: \_\_\_\_\_
- D. Rest and sleep \_\_\_\_\_

Have you ever been in an automobile accident?     Past Year     Past 5 years     Over 5 years     Never

Any accidents, falls, etc., that might have caused your problem? \_\_\_\_\_

**ANY CHIROPRACTOR CONSULTED IN THE PAST?** \_\_\_\_\_

Dates consulted \_\_\_\_\_ For what problem? \_\_\_\_\_

**Fees are payable at the time x-rays, examinations and treatments are received, unless other arrangements are made in advance. X-rays remain the property of the clinic.**

Patient's Signature: \_\_\_\_\_

Date: \_\_\_\_\_