



**In event of an emergency:**

Who should we contact? \_\_\_\_\_

Relation: \_\_\_\_\_

Home Phone #: \_\_\_\_\_

Who is your Medical Doctor? \_\_\_\_\_ Phone #: \_\_\_\_\_

**Health History:**

**Are you taking any medications? Y N**

**Do you have or ever had any of the following diseases or conditions?**

**Y N** Heart Attack/Stroke

**Y N** Heart Surg./Pacemaker

**Y N** Heart Murmur

**Y N** Congenital Heart Defect

**Y N** Mitral Valve Prolapse

**Y N** Artificial Valves

**Y N** Alcohol/Drug Abuse

**Y N** Venereal Disease

**Y N** Hepatitis

**Y N** HIV + / Aids

**Y N** Shingles

**Y N** Cancer

**Y N** Frequent Neck Pain

**Y N** Emphysema/Glaucoma

**Y N** Anemia

**Y N** High/Low Blood Pressure

**Y N** Psychiatric Problems

**Y N** Rheumatic Fever

**Y N** Severe/Frequent Headaches

**Y N** Kidney Problems

**Y N** Ulcers/Colitis

**Y N** Fainting/Seizures Epilepsy

**Y N** Sinus Problems

**Y N** Asthma

**Y N** Diabetes/Tuberculosis

**Y N** Difficulty Breathing

**Y N** Chemotherapy

**Y N** Lower Back Problems

**Y N** Artificial Bones/Joints

**Y N** Arthritis

Please list any other serious medical condition(s) you have or ever had:

Please list anything that you may be allergic to: \_\_\_\_\_

List previous surgeries/treatments with dates: \_\_\_\_\_

List any past serious accidents with dates: \_\_\_\_\_

Family Health History: \_\_\_\_\_

**Do you:** Take Supplements or Vitamins?  Yes  No / Exercise?  Yes  No

Are you on a special diet:  Yes  No / Since: \_\_\_/\_\_\_/\_\_\_

Do you smoke?  No  Yes / How Much? \_\_\_\_\_ How Long? \_\_\_\_\_

Are you wearing:  Heel Lifts  Sole Lifts  Inner Soles  Arch Supports

What is the age of your mattress? \_\_\_\_\_ Is it comfortable?  Yes  No

**For Women:** Are you taking Birth Control?  Yes  No

Are you Pregnant?  No  Yes/How long? \_\_\_\_\_ Nursing?  Yes  No

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and or managed care organization, to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature \_\_\_\_\_

Date \_\_\_/\_\_\_/\_\_\_

Adult Patient  Parent or Guardian  Spouse