Drugs you now take? ☐ Nerve Pills ☐ Pain Killers ☐ Blood Pressure Medication ☐ Insulin ☐ Other____________________

(How long? How often? For what?)____

Have you or anyone in your family had any of the following?

__HIV/AIDS	__Allergy Shots	__Appendicitis	__Breast Lumps	__Cancer
__Diabetes	__Epilepsy	__Gout	__Heart Disease	__Hepatitis
__Herniated Disc	__High Cholesterol	__Kidney Disease	__Liver Disease	__Miscarriage
__Multiple Sclerosis	__Osteoporosis	__Parkinson's	__Prostate Cancer	__Polio
__Stroke	__Thyroid Problems	__Venereal Disease		

FEMALES: are you pregnant? ☐ Yes ☐ No ☐ Not Sure Date of Last Menstrual period____________________

Check off any of the following **DANGER SIGNALS** you are experiencing:

Lower Back Pain......................☐	Numbing / Tingling in Legs / Feet................☐
Neck Pain.............................☐	Numbing /Tingling in Arms / Hands...........☐
Pain Between Shoulder Blades......☐	Carpal Tunnel.....................................☐
Migraine Headaches....................☐	Tension Across Top of Shoulders...............☐
Headaches.............................☐	Ringing in Ears....................................☐
Asthma................................☐	Dizziness...☐
Ear Infections..........................☐	Menstrual Cramps / Irregularity.................☐
Sinus Trouble..........................☐	Difficulty Sleeping.................................☐
Allergies................................☐	Nervousness..☐
Tired, Fatigued....................... ☐	Weight Trouble.....................................☐
Digestive Problems...................☐	Constipation..☐
Diarrhea................................☐	TMJ / Jaw Pain....................................☐

I hereby state that the information provided on all pages is true and correct. I will not hold Paul Family Chiropractic or any member of his staff responsible for any error or omissions that I may have made in the completion of this form.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Paul Family Chiropractic will help prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Paul Family Chiropractic will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered 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. If such payments are not made, I will be responsible for any and all costs associated with collecting payment on my account.

Signature Responsible Party: ____________________________________ Date:____________________

Guardian's Signature:____________________________________ Date:____________________