

## NEW PATIENT REGISTRATION

Today's Date \_\_\_\_\_ How did you hear about us?: \_\_\_\_\_

Name \_\_\_\_\_ Acct# \_\_\_\_\_ Int \_\_\_\_\_  
Last First Middle

(Complete Mailing)

Address \_\_\_\_\_ \*\*  
Street Apt# City State Zip

Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth \_\_\_\_\_

Home Phone # (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ \*\* Work Phone # (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ \*\*

Cell Phone # (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ \*\* E-mail Address: \_\_\_\_\_ \*\*

Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_ Phone# (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Phone# (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Is this visit routine/accident/illness/other: \_\_\_\_\_ If Accident (date) \_\_\_\_\_

### RESPONSIBLE PARTY INFORMATION

Name (Guarantor) \_\_\_\_\_  
Last First Middle

Guarantor Date Of Birth \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Address \_\_\_\_\_ Phone# (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Street City State Zip

Employer \_\_\_\_\_

Address \_\_\_\_\_ Phone # (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Name of Insurance \_\_\_\_\_ ID# \_\_\_\_\_ Grp# \_\_\_\_\_

(please complete other side)

\*\*Please notify our front office staff if there is an alternate address / phone number or form of communication\*\* that you wish us to contact you by other than your listed information above.

I have read and understand that this alternative is available to me

\_\_\_\_\_  
Date

Signature

## ACKNOWLEDGEMENT AND UNDERSTANDING

Please initial each item below.

1. \_\_\_\_\_ I hereby authorize Active Living Chiropractic P.C. to provide Chiropractic Services for me.
2. \_\_\_\_\_ I understand and agree that regardless of insurance coverage, I am liable for any charges incurred as a result of services rendered to me at Active Living Chiropractic Clinic.
3. \_\_\_\_\_ If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and cost of collections.
4. \_\_\_\_\_ I hereby assign all chiropractic benefits, including major medical benefits to which I am entitled, Medicare, private insurance and all other health plans, to Active Living Chiropractic, P.C. 132 E. Grant St Spearfish, SD 57783.
5. \_\_\_\_\_ I authorize release of patient's records to third parties requiring these records for determination of financial liability.

By signing this application I affirm under penalty that I have given true complete information.

Dated this \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_\_.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Guarantor Signature

\_\_\_\_\_  
Relationship to Patient

### AUTHORIZATION TO TREAT A MINOR

As a parent or legal guardian, I hereby authorize treatment for the following:

\_\_\_\_\_  
Patient's full name

DOB \_\_\_\_\_

to any chiropractic treatment deemed advisable, if a parent or legal guardian is not available when the child is brought in for treatment.

This authorization will be effective as of \_\_\_\_\_ and expires \_\_\_\_\_.

Signature \_\_\_\_\_ Witnessed by \_\_\_\_\_  
(Parent or Guardian)

## **Outpatient Clinic Financial Policy**

- 1) We accept cash, Visa and MasterCard.
- 2) All payments are due at the time of service, unless special arrangements have been agreed upon prior to visit.
- 3) All co-pays will be due at the time of service, once your insurance coverage has been verified and we have established what your responsibility is.
- 4) As a courtesy to our patients, we will bill your insurance company for you. Please keep in mind that if there is a discrepancy, we will let you know as soon as possible; however, we will not get involved with any dispute between you and your insurance carrier.
- 5) If you have a credit balance, we will reimburse you after payment has been received.
- 6) All supplements/vitamins, lab work, supports and other supplies **must** be paid for at the time they are received.
- 7) You are responsible for timely payment of you account.

## **Workers Compensation Claims**

- 8) All workers compensation cases will be billed directly to the insurance company, providing the appropriate paper work has been filled out and a claim is filed. If the claim is denied, we will bill your private insurance carrier, if you have coverage. Please keep in mind that if your claim is denied, then you are responsible for prompt payment of your account.

## **Personal Injury/Motor Vehicle Accidents**

- 9) Personal injury and auto accident cases will be billed to your auto insurance company, providing that a claim has been filed and the appropriate paper work has been done.
- 10) Keep in mind we do not do third party billings to other insurance companies.
- 11) If you choose not to file a claim with your auto insurance company, or are uninsured, your account will be treated as a cash account, and all fees will be due at the time of service.
- 12) Generally supplements/vitamins, lab work, supports and other supplies may not be covered by insurance companies, and must be paid for at the time they are received. Should the insurance company pay, we will reimburse you for the amount paid.

I have read, understand and agree with the above financial policy.

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Date

## Patient Rights

We believe that all patients should be treated in a manner that respects their basic rights as human beings. You, as patients, have the right to:

1. Voice grievances or concerns about your care to your ALC Physician.
2. Receive clear and complete information about your care and participate in the decisions concerning your treatment. If you have concerns about the front desk staff, insurance or billing, please contact the Operations Manager or ALC Physician.
3. Be treated with respect and courtesy by all those involved in providing care and information.
4. Privacy during interviews and examinations. All information about a patient's care and records will be treated in a confidential manner.

## Patient Responsibilities

1. Be as accurate and complete as possible when providing information about your medical history or condition.
2. Cooperate in following instructions given to you by those providing your health care.
3. Read and cooperate with the instructions provided by your doctor.
4. Ask for clarification about any aspect of your health care benefits that you do not fully understand.
5. Keep scheduled appointments or give adequate notice of delay or cancellation.
6. Treat those caring for you with respect and courtesy.

A simple **Referral of Your Friends and Family** is the best way to tell us your approval of the Quality of care at Active Living Chiropractic P.C.

## PRIVACY PRACTICES – PATIENT RECEPTION FORM

I have received or reviewed the privacy practice notice ( 4 pages) for Active Living Integrated Clinic, and understand the situations in which this practice may need to utilize or release my medical records. I also understand that I agreed to the use of those records when I initially applied for care at this office (my application for care) on my first visit, whenever that may have occurred.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print the Patient Name

## CONSENT FORM

### To Our Patients:

Chiropractic examination and therapeutic procedures (including spinal adjustment, massage, ultrasound, heat application, electrotherapy and manual muscle therapy) are considered safe and effective methods of care. Occasionally, however, complications may arise. Any procedure intended to help may have complications. While the chances of experiencing complications are small, it is the practice of this clinic to inform our patients about them. Side effects include, but are not limited to, soreness, inflammation, soft tissue injury, dizziness, burns, and temporary worsening of symptoms. More serious complications are extremely rare and their association with spinal adjustments (manipulation) is debated. These complications include injury to the arteries in the neck which may be associated with stroke and serious neurologic impairment, injuries to the spinal discs, and spinal fractures. Serious complications are estimated to be in the range of .5 – 2 incidents per million adjustments for adjustments of the neck, and 1 per million for adjustments of the low back. Additional information on side-effects, complications and effectiveness of spinal adjustments is available upon request.

*I have read and understand the above statements regarding treatment side-effects. I also understand that there is no guarantee or warranty for a specific cure or result.*

Patient signature

Date

### Please read the following carefully and initial each statement.

\_\_\_\_\_ I understand that if I have any prosthetics or surgical implants (including breast implants, an artificial joint, etc.), I should discuss this with the supervising physician because it may affect care.

\_\_\_\_\_ I understand that I play an important role in my own health care. Just as a patient can choose to discontinue care at any time, Active Living Chiropractic P.C. reserves the right to terminate a doctor-patient relationship if a patient is continually unable to comply with reasonable treatment plans.

## PERSONAL HEALTH HISTORY

Patient's Name \_\_\_\_\_ DOB \_\_\_\_\_ Date \_\_\_\_\_

Clinician \_\_\_\_\_

All information will be kept strictly confidential. Your responses will help determine if chiropractic treatment will benefit you. Unless we sincerely feel that your condition will respond satisfactorily, we will not recommend treatment. Please check the degree of all conditions you currently have or have had. To be responsible for your case, we need your complete health history.

**O = Occasional                      F = Frequent                      C = Constant**

<p><b>O F C</b> <b>Muscle / Joint</b></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Arthritis  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bursitis  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Foot trouble  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hernia  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Low back pain  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Lumbago  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Neck pain, stiffness  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Pain between shoulders</p> <p><b>General</b></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Allergy  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Chills  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Convulsions  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Dizziness  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Fainting  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Fatigue  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Fever  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Headache  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Loss of sleep  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Loss of weight  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Nervousness, depression  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Neuralgia  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Numbness  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sweats  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Tremors</p> <p><b>Cardiovascular</b></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hardening of arteries  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> High blood pressure  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Low blood pressure  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Pain over heart  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Poor circulation  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Rapid heartbeat  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Slow heartbeat  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Swelling of ankles</p> <p><b>Genitourinary</b></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bed-wetting  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Blood in urine  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Frequent urination  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Lack of kidney control  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Kidney infection  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Painful urination  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Prostate trouble  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Pus in urine</p>	<p><b>O F C</b> <b>Eye, Ear, Nose and Throat</b></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Asthma  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Colds  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Crossed eyes  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Deafness  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Dental decay  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Earache  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Ear discharge  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Ear noise  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Enlarged glands  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Enlarged thyroid  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Eye pain  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Failing vision  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Far sightedness  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Gum trouble  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hay fever  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hoarseness  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Nasal obstruction  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Near sightedness  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Nose bleeds  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sinus infection  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sore throat  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Tonsillitis</p> <p><b>Gastrointestinal</b></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Belching or gas  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Colitis  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Colon trouble  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Constipation  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Diarrhea  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Difficult digestion  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bloating abdomen  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Excessive hunger  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Gallbladder trouble  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hemorrhoids  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Intestinal worms  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Jaundice  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Liver trouble  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Nausea  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Pain over stomach  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Poor appetite  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Vomiting  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Vomiting of blood</p>	<p><b>O F C</b> <b>Skin</b></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Boils  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bruise easily  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Dryness  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hives or allergy  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Itching  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Skin eruptions (rash)  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Varicose veins</p> <p><b>Pain or numbness in</b></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Shoulders  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Arms  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Elbows  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hand  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hips  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Legs  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Knees  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Feet  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Painful tailbone  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Poor posture  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sciatica  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Spinal curvature  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Swollen joints</p> <p><b>Respiratory</b></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Chest pain  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Chronic cough  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Difficult breathing  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Spitting up blood  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Spitting up phlegm  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Wheezing</p> <p><b>Women only</b></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Congested breasts  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Cramps or backache  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Excess menstrual flow  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hot flashes  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Irregular cycle  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Lumps in breast  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Menopause  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Painful menstruation  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Vaginal discharge</p> <p>Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No          If yes, how many months? _____          How many children do you have? _____</p>	<p><i>Check any of the following conditions you currently have or have had:</i></p> <p><input type="checkbox"/> Alcoholism  <input type="checkbox"/> Anemia  <input type="checkbox"/> Appendicitis  <input type="checkbox"/> Arteriosclerosis  <input type="checkbox"/> Cancer  <input type="checkbox"/> Chicken pox  <input type="checkbox"/> Cholera  <input type="checkbox"/> Cold sores  <input type="checkbox"/> Diabetes  <input type="checkbox"/> Diphtheria  <input type="checkbox"/> Eczema  <input type="checkbox"/> Edema  <input type="checkbox"/> Emphysema  <input type="checkbox"/> Epilepsy  <input type="checkbox"/> Fever blisters  <input type="checkbox"/> Goiter  <input type="checkbox"/> Gout  <input type="checkbox"/> Heart disease  <input type="checkbox"/> Herpes  <input type="checkbox"/> Influenza  <input type="checkbox"/> Lumbago  <input type="checkbox"/> Malaria  <input type="checkbox"/> Measles  <input type="checkbox"/> Miscarriage  <input type="checkbox"/> Multiple sclerosis  <input type="checkbox"/> Mumps  <input type="checkbox"/> Pacemaker  <input type="checkbox"/> Pleurisy  <input type="checkbox"/> Pneumonia  <input type="checkbox"/> Polio  <input type="checkbox"/> Rheumatic fever  <input type="checkbox"/> Scarlet fever  <input type="checkbox"/> Stroke  <input type="checkbox"/> Tuberculosis  <input type="checkbox"/> Typhoid fever  <input type="checkbox"/> Ulcers  <input type="checkbox"/> Venereal disease  <input type="checkbox"/> Whooping cough</p>
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**Describe chiropractic problem:** \_\_\_\_\_

How long have you had this condition?	Is it getting worse? <input type="checkbox"/> Yes <input type="checkbox"/> No
Does it bother your (check appropriate box): <input type="checkbox"/> Work <input type="checkbox"/> Sleep <input type="checkbox"/> Other (please specify)	
What seemed to be the initial cause?	
Have you seen a chiropractor before? <input type="checkbox"/> Yes <input type="checkbox"/> No                      If yes, how long ago? _____	
For what reason?	
Are you under the care of a physician? <input type="checkbox"/> Yes <input type="checkbox"/> No                      If yes, for what reason?	

Patient's Name \_\_\_\_\_ DOB \_\_\_\_\_ Date \_\_\_\_\_

Clinician \_\_\_\_\_

Have you been hospitalized in the last 5 years?  Yes  No If yes, for major surgery?  Yes  No for serious injury?  Yes  No

Have you had any mental or emotional disorders?  Yes  No If yes, when?

Indicate the drugs do you now take?  Birth control pills  Tranquilizers  Pain Killers  Other (specify)

Do you wear:  heel lifts?  sole lifts?  inner soles?  area supports?  negative heels?  platform shoes?

What is the age of your mattress? \_\_\_\_\_ Is it  comfortable?  uncomfortable? Do you use a bedboard?  Yes  No

How is most of your day spent?  standing  sitting  walking  other (specify)

**Have you ever:** Yes No If yes, briefly explain.

- had a broken bone?  Yes  No

- been hospitalized?  Yes  No

- had strains or sprains?  Yes  No

- used a cane, crutch or other support?  Yes  No

- been struck unconscious?  Yes  No

- been hospitalized for other than surgery?  Yes  No

**Do you:**

- take minerals, herbs or vitamins?  Yes  No

- think you need minerals, herbs or vitamins?  Yes  No

- have any drug allergy?  Yes  No

**When did you last have:**

Never 0-6 mos. 6-18 mos. longer

- spinal x-ray?  Never  0-6 mos.  6-18 mos.  longer

- spinal examination?  Never  0-6 mos.  6-18 mos.  longer

- physical examination?  Never  0-6 mos.  6-18 mos.  longer

HABITS	None	Light	Mod	Heavy
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Soft Drinks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Salty Foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sugar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Artificial				
Sweeteners	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please list any other health conditions you have been treated for, or surgery you have had in the last ten years.

**FAMILY HEALTH HISTORY:** Information about your immediate family members, brothers, sisters, parents, and grandparents will give us a better understanding of your total health picture.

RELATIONSHIP	PRESENT AND PAST HEALTH PROBLEMS

Please mark your areas of pain on the figures below.