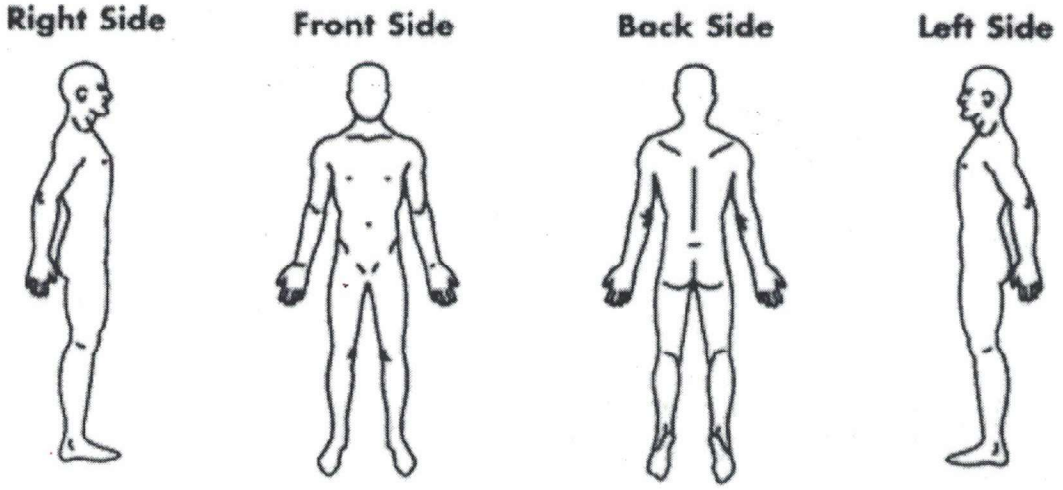
Additional Symptoms:_____.

Please mark area(s) of injury/symptoms utilizing the diagrams below:



MEDICAL HISTORY

Have you had these symptoms in the past? Yes No If Yes, When? _____

What treatment was performed? (circle all that apply):

Massage Chiropractic Medication Physical Therapy X-rays MRI

Other: _____

Present Weight: _____lbs.; Height: _____ft. _____ in.

Current Medication: _____

Hospitalizations/Surgeries: _____

Do you have a permanent disability rating? Yes No

Location_____; Rating_____%; When?_____

Important Medical Conditions:

_____

_____

I affirm that the information I have given is correct to the best of my knowledge and that it is my responsibility to inform this office of any changes in my medical status. I voluntarily consent to receive chiropractic care services that include diagnostic procedures, examination, and treatment. I authorize Most Chiropractic Clinic/Dr. Bridget Most to bill any charges incurred to my insurance company (if applicable) and assign benefits to be paid directly to Most Chiropractic Clinic/Dr. Bridget Most.

Signature of Patient/Guardian:_____

Date:_____