

CHECK THE FOLLOWING CONDITIONS YOU HAVE HAD:

- | | | | | |
|---|---|--|---|---|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Cold sores | <input type="checkbox"/> Goiter | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Scarlet fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Gout | <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Mumps | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Eczema | <input type="checkbox"/> Influenza | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Typhoid fever |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Lumbago | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Malaria | <input type="checkbox"/> Polio | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Chorea | <input type="checkbox"/> Fever blisters | <input type="checkbox"/> Measles | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Whooping cough |

PLEASE PRINT

What's your major complaint? _____

List surgical operation and years: _____

Drugs you now take: Nerve pills Pain killers Muscle relaxers
 "Pep" pills Tranquilizers Birth control pills

Others: _____

Age of mattress: _____ Comfortable Uncomfortable Do you use a bed board? _____

Are you wearing: Heal lifts Sole lifts Inner soles Arch supports

Have you been in an auto accident: Past year Past five years Over five years Never

Describe: _____

Have you ever had any mental or emotional disorders? Yes No When? _____

Have others in your family had such disorders? Yes No When? _____

HAVE YOU EVER:

Yes No

DESCRIBE BRIEFLY

- | | | | |
|--|--------------------------|--------------------------|-------|
| Been knocked unconscious? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Used a cane, crutch, or other support? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Been treated for a spine or nerve disorder? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Had a fractured bone? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Been hospitalized for anything other than surgery? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

DO YOU:

- | | | | |
|--|--------------------------|--------------------------|-------|
| Now take vitamins or minerals? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Think you may need vitamins or minerals? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Have an allergy to any drug? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

DATE OF LAST:	Less than 6 months	6-18 months	Over 18 months	Never
Spinal examination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical examination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood test	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chest X- ray	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spinal X-ray	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dental X-ray	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urine test	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

HABITS	Heavy	Moderate	Light	None
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"/>