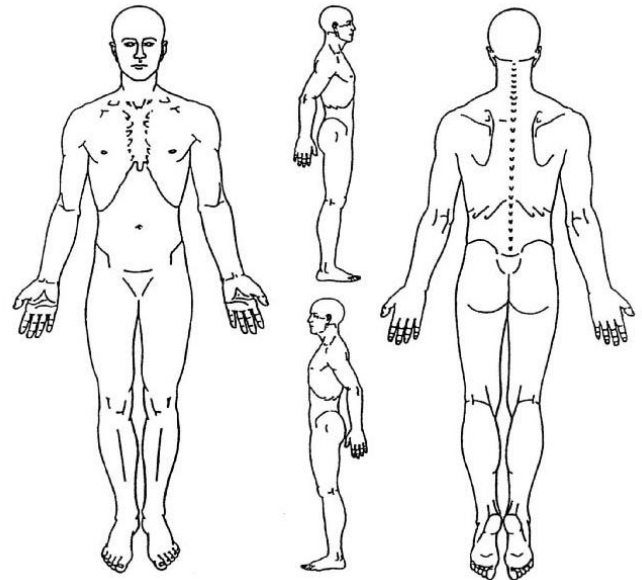


Please Check the Pertinent Boxes Below.

Condition or Symptom	Constantly Or Frequently (50-100%)	Sometimes/ Occasionally (0- 50%)	Family History Of Condition?
Headaches			
Migraines			
Neck Pain			
Shoulder Pain			
Arm/Hand Pain			
Mid Back Pain			
Low Back Pain			
Hip Pain			
Leg/Foot Pain			
Disc Problems			
Arthritis			
Other Joint Pain			
Numbness			
Joint Swelling			
Dizziness			
Nausea			
Weakness			
Fatigue			
Nervousness			
Insomnia			
Heart Problems			
Vision Changes			
Nose Bleeds			
Ringing in Ears			
Earaches			
Hearing Loss			
Cough			
Chest Pains			
Female Problems			
Allergies			
Asthma			
Cancer			
Osteoporosis			
Diabetes			
Hypoglycemia			
Digestive Problems			
Heartburn			
Urinary Problems			
Frequent Colds			
Skin Conditions			
Sciatica			
Other _____			
Other _____			

FEMALES: Is there a possibility of pregnancy? Y N

Use The Letters Below To Indicate The Type And Location Of Your Symptoms:
 A=Ache B=Burning S=Sharp
 N=Numbness P=Pins/Needles O=Other



I hereby authorize Creech Chiropractic to examine me, including X-rays (if indicated by my exam), and to release my records to anyone I designate. I further authorize treatment deemed necessary by the findings, and wish all my chiropractic records to be held in strict confidence and not be released to anyone without my written consent.

By signing below, I certify the accuracy of my family, medical and/or accident history and further certify that I present to Dr. Creech's office for evaluation and treatment of a health-related condition and for no other purpose.

 Signature of Patient or Guardian

 Date

First Day's Fees Are Due and Payable at the Time of Service Unless Insurance Benefits are Verified Beforehand.