



**Please circle any condition you have currently or have had previously:**

Stroke      Cancer      Heart Disease      Spinal Surgery      Seizures      Fracture      Scoliosis

Please list any current medications, vitamins, and supplements (prescription or over the counter):

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Please list any previous surgeries or hospitalizations and approximate date of occurrence:

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Have you ever had x-rays taken? If so, please list area x-rayed, where they were taken and approximate date:

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When was your last auto accident? \_\_\_\_\_ Have you ever been knocked unconscious? \_\_\_\_\_

Please list your current health goals below!

Health Goal: (ex. Get rid of migraines)	Date to Accomplish: (8/2015)	Significance of Goal: (ex. I want to be able to golf on a family vacation this summer)
1. _____ _____	_____	_____
2. _____ _____	_____	_____
3. _____ _____	_____	_____

**Insurance Information:**

Do you have any type of Health Insurance? (Circle):      Yes or No      If yes, Company: \_\_\_\_\_  
Are you covered by Medicare? Yes or No

*If yes, please give us your insurance card so we can photocopy it for our files!*

***I agree to assume responsibility for any charges created by my chiropractic care, and give consent to be examined and/or treated by Dr. Woodward and her staff.***

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