PAST HEALTH HISTORY- Fill out carefully as these problems can affect your overall course of care.

Previous Care for this Same Condition:

Have you seen other doctors for THIS CONDITION? YES or NO

If yes, Who?____

Type of treatment?____

Were you satisfied with your care? YES or NO

If no explain:____

Previous Chiropractic Care:

Doctor's Name:__________________________ Date of Last Visit:_______________________

Location:____

Were you satisfied with your care? YES or NO Why?

____

Do you wear any of the following? Heal lifts Innersoles Orthotics

Other:___________________________________ For how long?_______________________

Were they prescribed by a doctor? YES or NO

Condition's Effect on Job Performance:

- No Effect
- Mild Painful (Can do)
- Moderate Painful (limited ability)
- Moderate/Severe Limited Duty
- Severe No Limited Duty
- Severe (can't do limited duty)
- Resolved