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7. Are You Getting?	○ Better	○Worse ○Same	10.	Have You Had Recent Tr		
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8. If Your Complaints						
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Straining At Stool		Other		TO STATE OF THE ST		
Neck Movement	Sitting		11.	Has This Condition Exis	ted In The P	ast? OYes
9. If Your Complaints	Include Pain,	Is It Relieved By?	12.	Since Your Symptoms B	egan, Have	You Noticed A C
Nothing	Heat	Sitting		In? If Yes, Indicate O	nset Date	Duration
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○lce	Exercise	Other		Bladder Function		
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REVIEW OF SYST	EMC					
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2. What Hobbies D vou Participate in? List Hobbies: Occasionally Frequently Constantly 1. Occasionally Frequently 2. Occasionally Frequently 3. What Are Your Habits? 2. Occasionally Frequently 2. Occasionally Frequently 3. What Are Your Habits? 2. Occasionally Frequently 2. Occasionally Frequently 3. What Are Your Habits? 2. Occasionally Frequently 3. What Are Your Habits? 3. What Are Your Habits? 3. What Are Your Habits? 4. Hour You Been To A Chiropractor 4. Health Care 5. Do You Have A Family Physician 5. Do You Have A Family Physician 5. Do You Have A Family Physician 6. Have You Been Hospitalized in The Past 6. Five Years 6. Have You Had A Serious Accident in The Past 6. Five Years 7. Occasionally Frequently 7. Do You Have Any Drug Allergies 7. Family History 7. Family History 7. Do You Have Any Drug Allergies 7. Occuration Antibiotics 7. Occasionally Frequently 7. Do You Have Any Drug Allergies 7. Occupantly Taking Any Medication 7. Occasional Physician's Name & Address 7. Occupantly Town Frequently 7. Do You Have Any Drug Allergies 7. Occupantly Taking Any Medication 7. Occasional Physician's Name & Address 7. Occupantly Town Frequently Taking Any Medication 7. Occasional Physician's Name & Address 7. Occupantly Town Frequently Taking Any Medication 7. Occupantly The Past 7. Occupantly Taking Any Medication 7. Occasional Physician's Name & Address 7. Occupantly Town Frequently 7. Occupantly 7. Occasional Physician's Name & Address 7. Occupantly Town Frequently 7. Occupantly 7. Occasional Physician's Name & Address 7. Occupantly Taking Any Medication 7. Occasional Physician's Name & Address 7. Occasional Physician Physician Physician	C. REVIEW OF SYSTEMS (CONTINUED)	2. If you now have or you have had one of the following
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## Sepagemaker	Drug/Substance Abuse Never Yes	B High Blood Pressure B Multiple Scierosis
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Mother Companies	Five Years Yes No	
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Bro 3	Five Years Yes No	
e. Have You Had A Serious Accident In The Past Five Years		
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	1996 TIME VALUE CORP., Atlanta, GA HQ#3-2 Printed In The USA	

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E. OCCUPATIONAL INFORMATION - ACTIVITIES OF DAILY LIVING (CONTINUED)	5. HMO, PPO Plan Coverage	Yes No
5. Job Involves	Company	
a. Lifting	Policy #	
Never Frequently	6. Are You Covered By Medicare	Yes No
Occasionally Constantly	Medicare #	
Constantly	Medicare #	
b. Additional Job Requirements	7. Authorization To Release Records	To Patient's
Bending Twisting Carrying	Insurance Carrier	TO Fallent's
Stooping Turning Walking	Patient or Guardian's Signature	
Other	Tation of Standard Olynature	
6. What Is Your Primary Work Position \ Location?		
a. Position: b. Location:	G. PAYMENT	
Seated Desk Counter		
 Standing Workbench 	IF YOU HAVE MADE PRIOR FINANCIA	
Other Other	WITH OUR OFFICE THE FOLLOWING	PARAGRAPH WILL
	NOT APPLY TO YOU.	
c. If Seated, What Type Of Chair Do You Use?	I understand and agree that health and ac	cident policies are an
Executive Steno Bench	arrangement between an insurance Furthermore, I understand that this Of	
Stool	necessary reports and forms to assist me	e in making collection
	from the insurance company and that any a	mount authorized to be
7. Do You Wear Shoes Or Boots With High Heels?	paid directly to this Office will be credite receipt. However, I clearly understand and	
Never Seldom Occasionally Frequently	rendered to me are charged directly to me a	nd that I am personally
	responsible for payment. I also understan	nd that if I suspend or
8. Are You Right Or Left Handed?	terminate my care and treatment, any services rendered me will be immediately do	tees for professional
Right CLeft		
O De Week Astrikies Assessed V. B	I WILL BE PAYING TODAY BY: (If paying	ig by credit card
9. Do Work Activities Aggravate Your Present Complaints? Yes No		
o res ono		○Visa
10 Which Of The Following Boot Benedites Vens		American Express
10. Which Of The Following Best Describes Your Stress Level?	Other	
None Minimal Moderate Great	Account #	
Ordine Ordinaria Ordioderate Ogreat	Expiration Date	
11. How Do You Rate Your Physical Activity At Work?	Expiration Date	
Seated more than 50% of workday	Patient's Signature	Date
Light Manual Labor	r attent's digitature	Date
Moderate Manual Labor		
Heavy Manual Labor		
	Guardian or Spouse's Signature	Date
F. INSURANCE INFORMATION		
1. Is Your Condition Due To:		
An Automobile Accident		
A Personal Injury	Doctor's Signature	Date
A Job Injury		
W W-		
2. Do You Have Health Insurance Yes No		
Company	IS THERE ANYTHING ELSE YOU WOULD	LIKE US TO KNOW?
Policy #	○Yes ○No	
Vas No		
3. Is Your Spouse Employed Yes No		
Business		
Address		
4. Is Your Spouse The Primary Insured Yes No		
Company Policy #		
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