BRUCE MIRON, D.C.

MAJOR COMPLAINT (Please describe your major problem): _____

_____

_____

Date this condition began / How long have you had it? _____

How did this condition develop? (What caused it? How did it start?) _____

_____

Have you ever had this problem or a similar problem before? If yes, please explain: _____

_____

Have you ever received any treatment for this condition? If yes, please indicate the doctor's name, what was done, where and when, and what were your results? _____

_____

_____

Has this problem been getting better, worse, or staying the same? _____

Is there anything you do that makes your condition worse? _____

_____

Is there anything you do that makes your condition better? _____

Have you lost any work days? ( ) Yes ( ) No If yes, please give dates: _____

How has this condition affected your life?

A. Home life _____

B. Occupational life _____

C. Recreational life _____

D. Rest and sleep _____

ANY MEDICAL DIAGNOSIS OF YOUR COMPLAINT? _____

_____

Have you had ANY surgeries? If yes, please describe _____

_____

List any drugs you are now taking (prescription and non-prescription): ( ) Blood Pressure ( ) Pain Killers ( ) Muscle Relaxers ( ) Diet Pills ( ) Tranquilizers/Nerve Pills ( ) Insulin ( ) Birth Control Pills ( ) Other Names: _____

Last Eye Exam: _____ Last physical exam _____ Last dental checkup _____

Females: Last PAP Test/GYN checkup: _____

FAMILY HISTORY Please indicate which family members, have or had any of the following (please include parents and grandparents):

Arthritis _____ Cancer _____ Diabetes _____ Heart Disease _____ Back Problems _____ Scoliosis _____

Stroke _____ Any others, please list: _____

Habits:	Alcohol	Coffee	Tobacco	Rx Drugs	Exercise	Sleep	Appetite	Recreation	Sweets	Vitamin/Mineral Supplements
Heavy	____	____	____	____	____	____	____	____	____	_____
Moderate	____	____	____	____	____	____	____	____	____	_____
Light	____	____	____	____	____	____	____	____	____	_____
None	____	____	____	____	____	____	____	____	____	_____

*ANY OTHER CONDITIONS OR CIRCUMSTANCES THAT THE DOCTOR SHOULD BE AWARE OF?

_____

HOW WOULD YOU LIKE US TO HANDLE YOUR PROBLEM?

_____ Temporary Relief _____ Maximum Correction

I UNDERSTAND THAT ALL FEES ARE PAYABLE AT THE TIME SERVICE IS RENDERED UNLESS SPECIAL ARRANGEMENTS ARE MADE IN ADVANCE WITH THE DOCTOR.

I hereby authorize the doctor to release any information required to process any claims on my behalf. I have provided the above information as truthful and to the best of my knowledge.

Signed _____ Date _____