KAISER
CHIROPRACTIC PHYSICAL THERAPY

If you have experienced any of the following conditions in the past mark a "P" on the line provided. If you are currently experiencing any of the following conditions please mark a "C" on the line provided. *(check all that apply)*

___ heart attack	___ stroke	___ difficulty with bowel movements	
___ diabetes	___ glaucoma	___ fainting spells	___kidney stones
___ difficulty with urination	___ bloody stools	___ arthritis	___gall bladder
___ prostate trouble	___ anemia	___ cancer	___ asthma
___ AIDS	___ ulcers	___ diverticulosis	___ menstrual cramping
___ dizziness	___ loss of memory	___chest pain	___ shortness of breath
___ constipation	___ diarrhea	___ general fatigue	___ sudden weight loss
___ nausea	___ tuberculosis	___soreness (joints)	___ loss of hearing
___ ears ringing	___ headache	___ migraine	___ epilepsy
___ gout	___ muscle cramps	___ syphilis	___ sprained ankle R L
___ knee/hip replacement	___ broken bones		

___other*(specify)*_____

General Activities *(check all that apply)*

___ sleep on waterbed	___ read in bed	___ fall asleep in recliner/on couch
___ sleep on stomach	___ needlepoint/knitting	___ use two or more pillows to sleep with
___ sewing	___ lift weights/wt. mach.	___ play video games (_____ hrs per day)
___ exercise _____x/wk	___ jog _____x/wk	___ computer use (_____ hrs per day)
___ swim	___ use healthrider	___ watch television (_____ hrs per day)

Authorization

I certify that I have read and I understand the above information to the best of my knowledge. The questions above have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize this office to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to this office benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Patient's Signature _____ Date _____

(signature of parent if the patient is a minor)