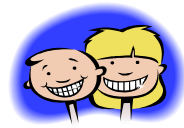




# Preferred Chiropractic

If you or any member of your family have experienced any of the following, please mark the appropriate box.



Condition	Self	Spouse	Mother	Father	Sibling	Child	Child	Child
Allergies								
Anemia								
Appendicitis								
Arthritis								
Asthma								
Breathing Problems								
Bursitis								
Cancer								
Chest Pain								
Colitis								
Diabetes								
Digestive Problems								
Dizziness								
Earaches								
Eye Problems								
Frequent Colds								
Headaches								
Hearing Problems								
Heart Problems								
Hemorrhoids								
Hernia								
Impotency								
Liver Problems								
Low Back Pain								
Menstrual Problems								
Mid Back Pain								
Neck Pain								
Nervousness								
Neuritis								
Pain in Arms or Hands								
Pain in Legs or Feet								
Shingles								
Shoulder Pain								
Sinus Problems								
Skin Disorders								
Throat Problems								
Thyroid Disorders								
Tonsillitis								
Urination Problems								

Signature \_\_\_\_\_ Date \_\_\_\_\_

