Surgery (Please include all surgeries within the LAST 5 YEARS)

1. _____ **Year:** _____

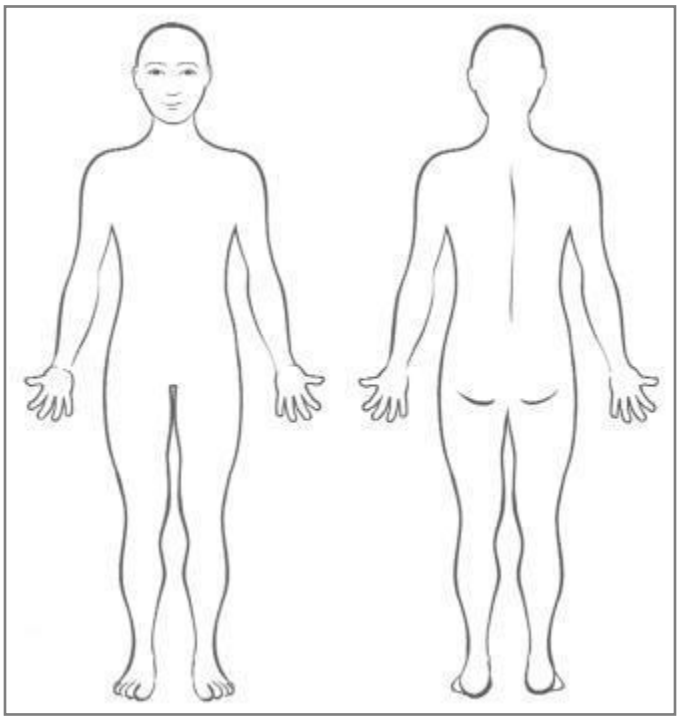
2. _____ **Year:** _____

3. _____ **Year:** _____

Are you now or have you suffered from any of the following:

- ☐ Stroke
- ☐ Fatigue
- ☐ Migraine
- ☐ Nervousness
- ☐ Arthritis
- ☐ Numbness
- ☐ Pregnant
- ☐ Spinal curvature
- ☐ Heart Disease
- ☐ High blood pressure
- ☐ Heart attack
- ☐ Dizziness
- ☐ Headache
- ☐ Cancer
- ☐ Diabetes
- ☐ Swollen joints

Please mark your area of pain on the picture below



Please rate the intensity of your pain:

Absent 0 _____ 5 _____ 10 *Extreme*

Frequency:

☐ Occasional ☐ Intermittent ☐ Frequent ☐ Constant

Are symptoms:

☐ Getting worse ☐ Getting better ☐ Staying the same

CONSENT TO TREAT A MINOR CHILD:

I hereby authorize this office to administer chiropractic as deemed necessary for my child.

(Parent/Legal Guardian) Signature: _____ Date: _____

FINANCIAL/INSURANCE POLICY:

I understand and agree that health and accident insurance policies are an arrangement between and insurance carrier and myself. Furthermore, I understand that the Doctor's Office will process any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment.

Signature: _____ Date: _____

Policy Holder's name: _____ DOB: _____

AUTHORIZATION TO RELEASE INFORMATION

To: Richard W. Sadowski D.C.

You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered by you, and I hereby release you of any consequences thereof.

Signature: _____ Date_____