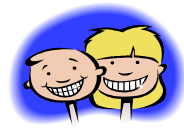




# Preferred Chiropractic

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

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