SOCIAL HISTORY

Circle all that apply

Do you exercise? Regularly Frequently Occasionally Never **At what level?** Competitively High Medium Low

Sufficient Rest? Always Mostly Sometimes Never **Hours of Sleep?**_____

Smoking Status: Current smoker Smoking start date:_____ Packs/day:_____ Current some day smoker
Former smoker Quit date:_____ Never smoker
In an effort to quit smoking, I am currently taking:_____

Do You Drink Alcohol? Yes No Drinks per Day:_____

Hobbies:_____

YOUR FAMILY HISTORY

If anyone in your immediate family has had any of these diseases, please check those that apply.	Grand-mother (Dad)	Grand-father (Dad)	Grand-mother (Mom)	Grand-father (Mom)	Father	Mother	Siblings
Cancer							
Heart Disease							
High Blood Pressure							
Stroke							
Diabetes							
Back or Neck Problems							

IF YOUR PROBLEM IS DUE TO A MOTOR VEHICLE CRASH OR A PERSONAL INJURY, PLEASE FILL OUT THIS NEXT SECTION.

Date of Crash / injury:_____ Time of day:_____ a.m. / p.m. Location:_____

Please describe the circumstances in detail: _____

_____

_____

Was a police report made? Yes No Was An Injury Report made? Yes No

Who else was in the vehicle?_____ Were They Injured? Yes No

Have you lost any days from work? Yes No If yes, how many? _____

Your ins.co.: _____ Policy #:_____ Claim #:_____

Adjuster's name and Phone #: _____ Address:_____

Other party's name and ins. co.: _____ policy #:_____

Address: _____ City: _____ State: _____ Zip: _____

ATTORNEY

Name: _____ Phone: _____

Address:_____ City: _____ State: _____ Zip: _____

Were there any witnesses? Yes No Name(s): _____