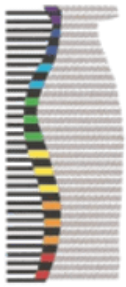


# THILL CHIROPRACTIC CENTER

1040 BUSSE HIGHWAY, SUITE 101, PARK RIDGE, IL 60068| P.847-971-4184

**Please provide your Picture ID & Insurance Card to photocopy.**

Name: Last _____ First _____

Home Address: _____

Phone Number: _____ Cell: _____

Email: _____

Gender: M □ F □ Age: _____ Birthday: _____

Occupation: _____ Company: _____

Address: _____

Work Phone: _____

Do you have a Primary Medical Doctor? _____ Last Check Up Date? _____

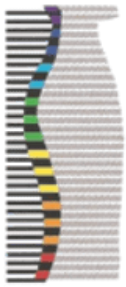
What were the results? _____

Please list all drug & food allergies? _____

What Medications are you currently taking? _____

Does your family medical history include any of the following? (circle)

Heart Disease / Hypertension / Cancer / Diabetes / Arthritis



# THILL CHIROPRACTIC CENTER

1040 BUSSE HIGHWAY, SUITE 101, PARK RIDGE, IL 60068| P.847-971-4184