APPLICATION FOR TREATMENT

Personal Information

Name: _____ Today's Date: _____/_____/_____

Address: _____

E-Mail Address: _____

Birth Date: _____/_____/_____ Age: _____ Are You Pregnant: ☐ Yes ☐ No

Employer's Name & Address: _____

Occupation: _____ Work Phone No.: _____

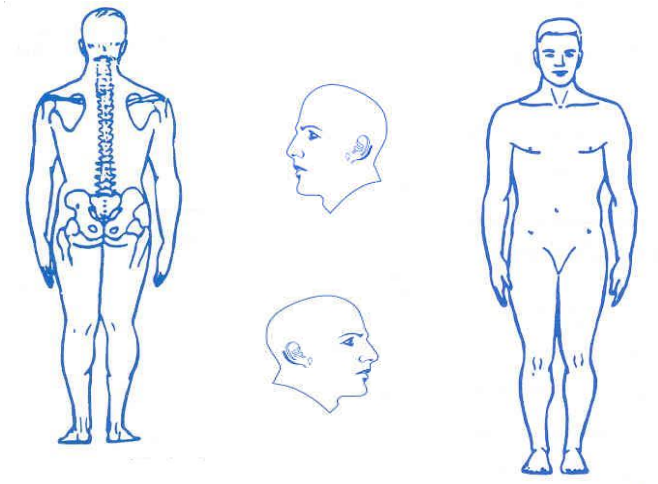
Home Phone No.: _____ Cell Phone No.: _____

Who Referred You To Our Office?: _____

What Type of Care Do You Desire?: ☐ Temporary Relief ☐ Lasting Correction ☐ Best Care Possible

Current Health Condition

Please circle the exact location of any pain you are experiencing. Then describe the type of pain, i.e., dull, sharp constant, on & off, etc.



In order of importance, list the health problems you are most interested in getting corrected.

1. _____
2. _____
3. _____
4. _____
5. _____

In order of severity, list those body functions that you are unable to perform, or that produce pain upon performance, i.e., walking, sitting, bending, etc.

1. _____
2. _____
3. _____
4. _____
5. _____

When was the first time you noticed this problem?:

_____

_____

Describe any accidents, falls, injuries, sudden movements, etc. that may have caused your problem: _____

_____

Have you had any similar health problems or injuries before? ☐ Yes ☐ No If yes, please explain: _____

_____

Names of all other doctors you have seen for this problem: _____

_____

Diagnosis and type of treatment you received (please include where and when you received treatment, and the results): _____

_____

Has your health problem been: ☐ Improving ☐ Worsening ☐ Staying the Same

Please describe anything you do that improves your condition, or worsens it: _____

_____

Please check off and describe how this problem interferes with your work and/or personal life:

☐ Home Activities Effected: _____

(Please Complete Reverse Side)

☐ Work Activities Effected: _____

Have you missed any work days? ☐ Yes ☐ No If yes, dates missed: _____

☐ Recreational Activities Effected: _____

☐ Rest or Sleep Effected: _____

Previous Health History

During the last year, has a doctor treated you for any health problem? ☐ Yes ☐ No
If yes, please explain: _____
_____
_____

Have you ever received Chiropractic care? ☐ Yes ☐ No If yes, please list the doctor's name, location of office and for what problems: _____
_____
_____

Please check off the drugs you are now taking: ☐ Pain Killers ☐ Muscle Relaxers ☐ Anti-inflammatory
☐ Blood Pressure Medication ☐ Insulin ☐ Birth Control Pills ☐ Tranquilizers ☐ Diet Pills
☐ Nerve Medication ☐ Sleeping Pills ☐ Anti-depressants ☐ Other (please list): _____
_____

List the approximately dates of any accidents, operations or serious injuries (including broken bones) you have had: _____
_____
_____

If you have been in an automobile accident, when? ☐ This Year ☐ Last Year ☐ Past 5 Years ☐ Over 5 Years

Please check off the following that apply to you within the past 2 years: ☐ Went to Health Spa
☐ Purchased Vitamins ☐ Purchased Health Food ☐ Received a Massage

Please explain why you choose to do any of the above: _____
_____

Family Health History

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Names & Ages of Children: _____

Name of Wife of Husband: _____

Spouse's Employer: _____ Business Phone: _____

Financial Responsibility

Who is responsible for your bill? ☐ I am ☐ Spouse ☐ My Employer ☐ Insurance
☐ Other _____
Type of Insurance: ☐ Worker's Comp ☐ Health ☐ Automobile
Insurance Company's Name & Address: _____
_____

If you are responsible for your health care fees, payment will be made by: ☐ Cash ☐ Check ☐ Credit Card

Your fees are due and payable at the time examinations, X-rays, and treatments are received, unless other arrangements have been made in advance. X-rays remain property of this clinic.

I, the undersigned, hereby give permission for treatment.

Patient's Signature: _____

Social Security No.: _____ Date: _____/_____/_____

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