APPLICATION FOR TREATMENT

Personal Information

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

Address: _____

E-Mail Address: _____ Cell Phone No.: _____

Work Phone No.: _____ Home Phone No.: _____

Birth Date: _____/_____/_____ Age: _____ □ Male □ Female … □ Pregnant:

Employer's Name & Address: _____

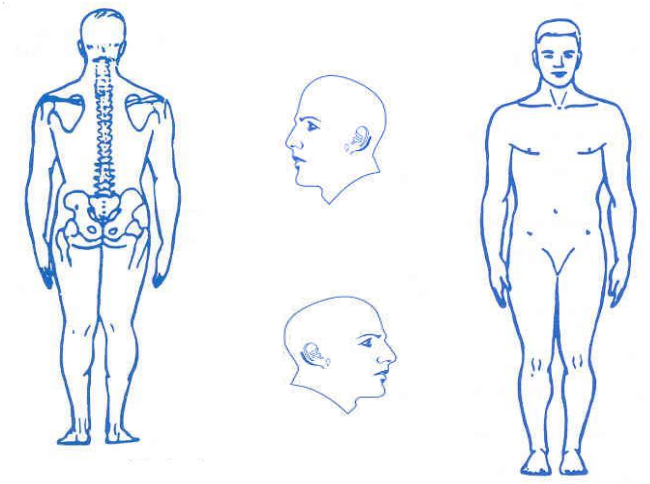
Occupation: _____

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: _____/_____/_____

