Patient Name –

APPLICATION FOR TREATMENT

Name_____Today's Date _____

Address: _____

Birthdate:_____ Are you pregnant? ☐ Yes ☐ No

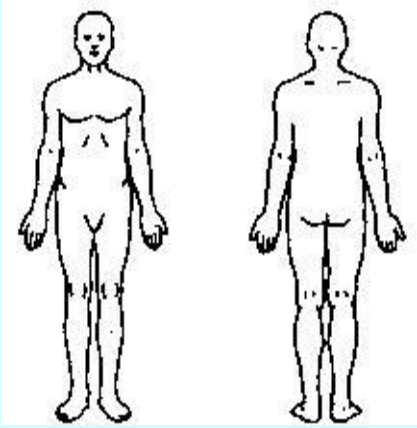
Employer's Name & Address: _____

Occupation:_____Work Phone_____Home Phone _____

Email Address_____Cell Phone_____

What type of care do you desire? ☐ Temporary Relief ☐ Lasting Correction ☐ Best Care Possible

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 correcting:

1._____

2._____

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._____

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:_____

_____

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 or worsens your condition:_____

_____

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

☐ Home activities affected:_____

☐ Work activities affected: _____

Have you missed any work days? How Many? _____

☐ Recreational activities affected:_____

☐ Rest or sleep affected: _____

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Have you been treated by a doctor within the last year?_____

If yes, please explain: _____

_____

Name, Address, and Phone Number of Medical Doctor:_____

_____

Have you ever received Chiropractic care?_____ If yes, please list the doctor's name, address and what your problem was at the time:_____

_____

Please check off the drugs you are now taking: □ Pain Killers □ Muscle Relaxers □ Anti-inflammatory

□ Blood Pressure Medication □ Insulin □ Tranquilizers □ Diet Pills □ Birth Control

□ Nerve Medication □ Anti-Depressants □ Other (please list): _____

_____

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

_____

_____

If you have been in an auto 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 a Health Spa

□ Purchased Vitamins □ Purchased Health Foods □ Received a Massage

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

_____

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

Names and Ages of Children_____

Name of Spouse_____

Spouse's Employer_____Work Phone_____

Who is responsible for your bill? □ I am □ Spouse □ My Employer □ Insurance

Type of Insurance: □ Worker's Comp. □ Health □ Automobile

Insurance Company's name and 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 examination, 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_____