APPLICATION FOR TREATMENT

Personal Information

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

Address: _____ City/State/Zip: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Email: _____ Occupation: _____

Employer's Name and Address: _____

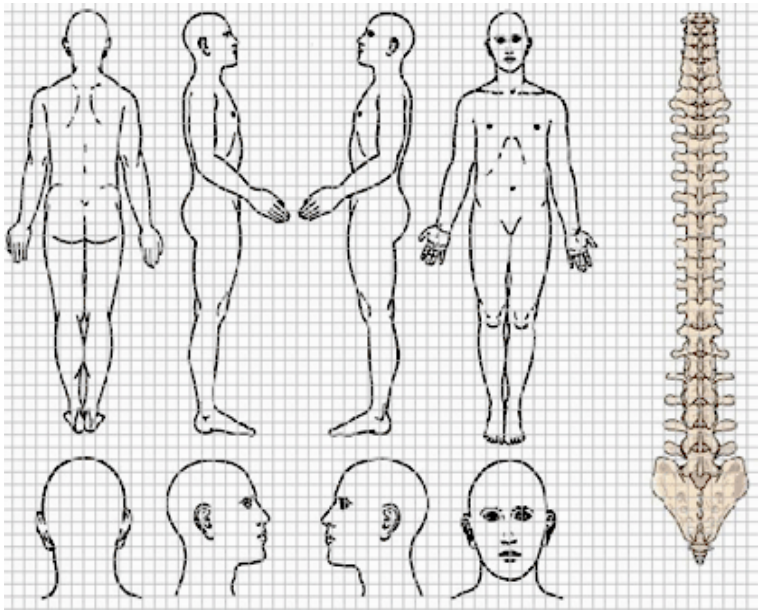
Birth Date: ____/____/____ Age: _____ Are you Pregnant? ☐ Yes ☐ No if yes, due date: _____

How did you hear about us: _____

What type of care do you desire: ☐ Temporary Relief ☐ Lasting Health

Current Health Condition

Please circle the exact location of any pain you are experiencing. Then describe the type of pain, i.e. dull, sharp, achy, constant, on & off, etc. If the pain travels indicate that with an arrow.



In order of importance, please list the health problems you are most interested in getting corrected in our office:

1) _____
2) _____
3) _____
4) _____

When was the first time you noticed these:

1) _____
2) _____
3) _____
4) _____

In order of severity, list anything you are unable to do or functions you are unable to perform due to these problems:

_____
_____
_____
_____

What do you think caused your problems: _____

Describe any accidents, falls, injuries in your past that may have caused or aggravated your condition: _____

_____

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

_____

Names of other doctors you have seen for these conditions: _____

_____

Diagnosis and treatment received: _____

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

Please describe anything that improves your condition: _____

Please describe anything that worsens your condition: _____

Does your problem interfere with: ☐ Rest/Sleep

☐ Home activities: _____

☐ Work activities: _____

☐ Recreational activities: _____

(Please also complete reverse side)

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 before? ☐ Yes ☐ No if yes, please indicate the name and location of the doctor and the last time you saw him/her: _____

_____

Check the type of drugs you are taking: ☐ Pain Killers ☐ Muscle Relaxers ☐ Diet Pills ☐ Anti-Inflammatory ☐ Blood Pressure Medication ☐ Insulin ☐ Birth Control Pills ☐ Tranquilizers ☐ Nerve Medication ☐ Sleeping Pills ☐ Anti-Depressants ☐ Cholesterol lowering Medications ☐ Other: _____

List dates and description of any serious injuries you have had (broken bones, car accidents, operations, etc.): _____

_____

_____

If you have been in an automobile accident when was it? ☐ This Year ☐ Past 5 Years ☐ Over 5 Years Ago

Please check off the following that apply to you within the past 2 years: ☐ Went to a health spa ☐ Purchased Vitamins or Supplements ☐ Purchased Health Foods ☐ Received a Massage

Why did you do any of the above? _____

Family Information

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

Name of wife or husband: _____

Names and ages of children: _____

_____

Emergency Contact: _____ Phone: _____

Does any one in your family suffer from: ☐ Allergies ☐ Arm Pain – Numbness/tingling ☐ Arthritis ☐ Asthma ☐ Back Pain ☐ Bursitis/Tendonitis ☐ Cancer ☐ Constipation ☐ Diabetes ☐ Disc Problems ☐ Emphysema ☐ Epilepsy ☐ Hand Pain – Numbness/tingling ☐ Hay Fever ☐ Headaches ☐ Heart Trouble ☐ High Blood Pressure ☐ High Cholesterol ☐ Insomnia ☐ Kidney Trouble ☐ Leg Pain – Numbness/tingling ☐ Liver Trouble ☐ Low Blood Pressure ☐ Migraines ☐ Neck Pain ☐ Nervousness ☐ Neuralgia ☐ Pinched Nerves ☐ Reflux ☐ Scoliosis ☐ Shoulder Pain ☐ Sinus Trouble ☐ Stomach Trouble ☐ Whiplash Injuries

Financial Responsibility

Who is responsible for your bill? ☐ I am ☐ Spouse (spouse's phone#: _____) ☐ My Employer ☐ Insurance ☐ Other: _____

Type of Insurance: ☐ Auto ☐ Worker's Comp. ☐ Health

Responsible Party's Name, Address, Phone: _____

_____

Payment will be made for your out-of-pocket health fees by: ☐ Cash ☐ Check ☐ Credit Card

Your fees/co-pays are due and payable at the time of service unless other arrangements have been made in advance.

I, the undersigned, hereby give permission for evaluation and/or treatment.

Print Name: _____ Sign: _____ Date: ____/____/____