APPLICATION FOR TREATMENT

Please check the type of care desired: __ Temporary Relief __ Lasting Correction

__ Check here if you want the Doctor to recommend the best type of care for you. Date ____________________

Name ____________________ Date of Birth ____________________

Address ____________________ City __________ State ______ Zip Code __________

Home Phone Number ____________________ Phone at Work ____________________

Email Address ____________________ Cell Phone Number ____________________

Check if you are: __ Married __ Single __ Widowed __ Divorced __ Separated

Name of spouse: ____________________ Ages of Children: ____________________

Where are you or your spouse employed? ____________________

Your days off ____________________ Referred to our office by ____________________

Who is your Primary Care Physician (PCP)? ____________________

Do we have your permission to send your primary care physician at letter? __ Yes __ No

Who is responsible for your bill? __ Self __ Spouse __ Employer __ Insurance __ Other: ____________________

How payment will be made: Type of insurance: ____________________

Cash ______________ Workers' Comp ______________ Health Insurance ______________

Check ______________ Credit Card ______________ Automobile Ins. Policy ______________

Name of Company and address ____________________

____

If you are in pain, please mark the exact location of your pain on the diagram below. Also describe the type and frequency of your pain, as well as any activity which brings on or aggravates the pain. For example: dull, sharp, constant, off and on, when standing, when sitting, etc.

COMPLETE THESE DIAGRAMS

MAJOR COMPLAINT

(Please describe only your major problem)

____

How did this condition develop? (What caused it? How did it start?) ____________________

____

When was the very first time you were aware of this problem? ____________________

Have you ever had this problem or a similar problem before? (If yes, please explain) ____________________

____

Have you ever received any treatment for this condition? If yes, where and when, and what were your results? ____________________

____

Has this problem been getting better, worse, or staying the same? ____________________

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(PLEASE COMPLETE THE REVERSE SIDE)

Is there anything you do that makes your condition worse? ______________________________

____

How has this condition affected your life?

A. Home life ______________________________
B. Occupational life ______________________________
C. Recreational life ______________________________
D. Rest and Sleep life ______________________________

Have you ever been in an automobile accident? ___ Past year ___ Past 5 years ___ Over 5 years ___ Never

ANY ACCIDENTS, FALLS, ETC., THAT MIGHT HAVE CAUSED YOUR PROBLEM ______________________________

____

What surgery has been done? ______________________________

____

Are you pregnant? ___ Yes ___ No

DRUGS YOU NOW TAKE: ___ Nerve pills ___ Pain Killers ___ Muscle Relaxers ___ "Pep" pills ___ Tranquilizers ___ Insulin ___ Birth Control Pills

Other (please list) ______________________________

ANY CHIROPRACTOR CONSULTED IN THE PAST? Name ______________________________

Dates consulted ______________ For what problem? ______________________________

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

Patients Signature ______________________ Social Security No. ______________ Date ______________

IF YOURS IS AN ACCIDENTAL INJURY, PLEASE COMPLETE THE FOLLOWING QUESTIONS

Date of accident ______________ Hour ________ AM___ PM ___ Location ______________________

How did accident occur? ___ Auto Collision ___ On-the-Job Injury ___ Other ______________________

If not an auto collision, please describe the circumstances ______________________________

____

____

Did you report the injury to your foreman or employer? ___ Yes ___ No

Did he (they) recommend care at our office? ___ Yes ___ No

If auto accident, were you s Driver ___ Passenger ___ Pedestrian

If auto collision, were you struck from ___ Behind ___ Right Side ___ Left Side ___ Front ___ Auto was parked

Did your car strike the other(s) involved? ___ Yes ___ No Or did the other car strike yours? ___ Yes ___ No ___ Undetermined

As the result of the accident, were traffic citations issued to you? ___ Yes ___ No To the driver of the other car? ___ Yes ___ No

To the driver of your car? ___ Yes ___ No List the extent of the injuries as you know them ______________________

____

______________________________ Did you require post-accident hospitalization? s Yes s No

CHECK SYSMPTOMS YOU HAVE NOTICED SINCE ACCIDENT

___ Headache	___ Irritability	___ Numbness in Toes	___ Face Flushed	___ Feet Cold
___ Neck Pain	___ Chest Pain	___ Shortness of Breath	___ Buzzing in Ears	___ Hands Cold
___ Neck Stiff	___ Dizziness	___ Fatigue	___ Loss of Balance	___ Stomach Upset
___ Sleeping Problems	___ Head seems too heavy	___ Depression	___ Fainting Spells	___ Constipation
___ Back Pain	___ Pins & Needles in Arms	___ Light Bothers Eyes	___ Loss of Smell	___ Cold Sweats
___ Nervousness	___ Pins & Needles in Legs	___ Loss of Memory	___ Loss of Taste	___ Fever
___ Tension	___ Numbness in Fingers	___ Ears Ring	___ Diarrhea	___ ____________

Symptoms other than above ______________________________

Have you lost any days of work? ___ Yes ___ No Dates ______________________________

Name of your Insurance Company involved ______________________________

Name of Insurance Company of person responsible for injuries ______________________________

Have you been contacted by an Insurance Adjuster or Company Representative regarding this claim? ___ Yes ___ No

Do you have an attorney who has advised you in this case? ___ Yes ___ No Name ______________________

Address of attorney ______________________________ Phone number ______________________