

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: _____

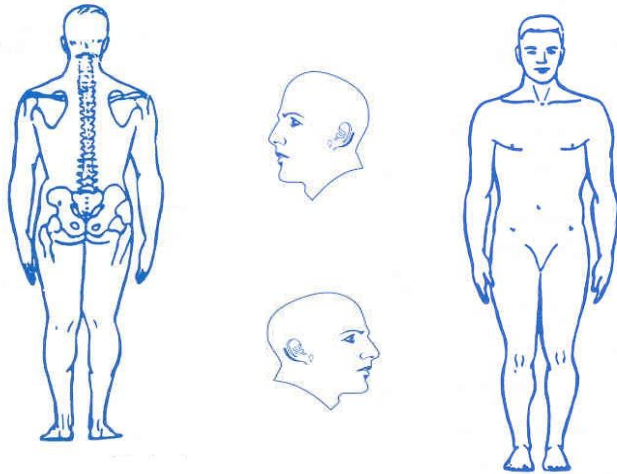
Work Phone No.: _____ Home Phone No.: _____

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: _____

(Por Favor Llame el Reverso)

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: ____/____/____