

# BOUTROS CHIROPRACTIC & WELLNESS

INJURY CARE-NUTRITION-REHABILITATION

## APPLICATION FOR TREATMENT

Date \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ Birthdate \_\_\_\_\_

Please circle : Male or Female Social Security # \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_

Home Phone Number \_\_\_\_\_ Mobile Phone # \_\_\_\_\_ Email Address \_\_\_\_\_

How did you hear about us? \_\_\_\_\_ Who referred you? \_\_\_\_\_

Check if you are: Married \_\_\_\_\_ Single \_\_\_\_\_ Widowed \_\_\_\_\_ Divorced \_\_\_\_\_ Separated \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Emergency contact \_\_\_\_\_ Phone # \_\_\_\_\_ Relationship \_\_\_\_\_

Please circle one : Cash Medicare Commercial/Group Auto Workers Comp

Who is responsible for your bill? Self \_\_\_\_\_ Spouse \_\_\_\_\_ Employer \_\_\_\_\_ Insurance \_\_\_\_\_ Other \_\_\_\_\_

Primary Insurance: \_\_\_\_\_ ID \_\_\_\_\_ Group \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ ID \_\_\_\_\_ Group \_\_\_\_\_

Primary care physician: \_\_\_\_\_ Phone # \_\_\_\_\_

How and when did the symptoms first occur: \_\_\_\_\_

Is this accident related? Yes No Employment Related? Yes No

**Patient's or Authorized Person's Signature:** I authorize the release of any medical or other information necessary to process my insurance claim. This is to serve as a long-term authorization card.

Signed \_\_\_\_\_ Date \_\_\_\_\_

**Insured's or Authorized Person's Signature:** I authorize payment of medical benefits to Boutros Chiropractic & Wellness for the services described on the insurance form. This authorization is to apply to all occasions of service until it is revoked in writing.

Signed \_\_\_\_\_ Date \_\_\_\_\_

Fees are payable at the time x-rays, examination and treatments are received unless other arrangements are made in advance. X-rays remain the property of this clinic. I hereby give permission for treatment.

Signature of Patient \_\_\_\_\_ Date \_\_\_\_\_

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Please describe the principal health problems for which you came to this office. \_\_\_\_\_

\_\_\_\_\_

How and when did symptoms first occur? \_\_\_\_\_

List any other doctors seen for these problems \_\_\_\_\_

List diagnosis(es) and type of treatment(s) \_\_\_\_\_

\_\_\_\_\_

Does this interfere with your normal living and work? Yes \_\_\_ No \_\_\_ In what way? \_\_\_\_\_

Have you lost any days of work? Yes \_\_\_ No \_\_\_ Dates \_\_\_\_\_

Have you had similar symptoms or injuries before? Yes \_\_\_ No \_\_\_ If yes, explain \_\_\_\_\_

\_\_\_\_\_

List the names of any relatives that have or have had a similar problem \_\_\_\_\_

\_\_\_\_\_

List the approximate dates of any operations, unusual diseases, serious illnesses or accidents you have had (include any broken bones)

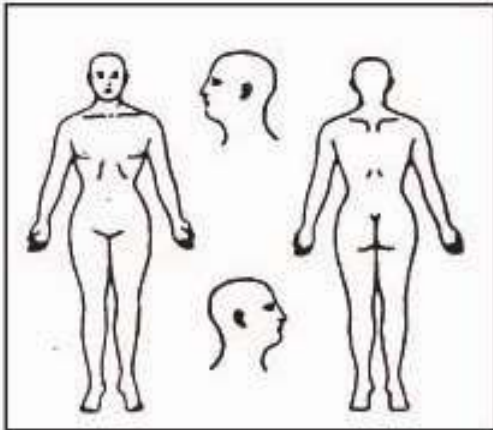
\_\_\_\_\_

\_\_\_\_\_

List all drugs or medication that you have used recently (i.e., aspirin, sleeping pills, birth control pills, etc.) \_\_\_\_\_

\_\_\_\_\_

Please mark your areas of pain on the figures below.



List the conditions that you are most interested in getting corrected. List in order of importance:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

What functions are you unable to perform or induce pain upon performance? List in order of severity. (Example: sitting, walking, bending, lying down, etc.)

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_