Application for Treatment

Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip code: _____

Home Phone: _____ SS# _____ DOB: _____

E-mail: _____

Place of employment: _____
Work phone: _____ Mobile # _____

Spouse's Name: _____ Spouse's DOB: _____
Work phone: _____ Email address: _____ Mobile # _____

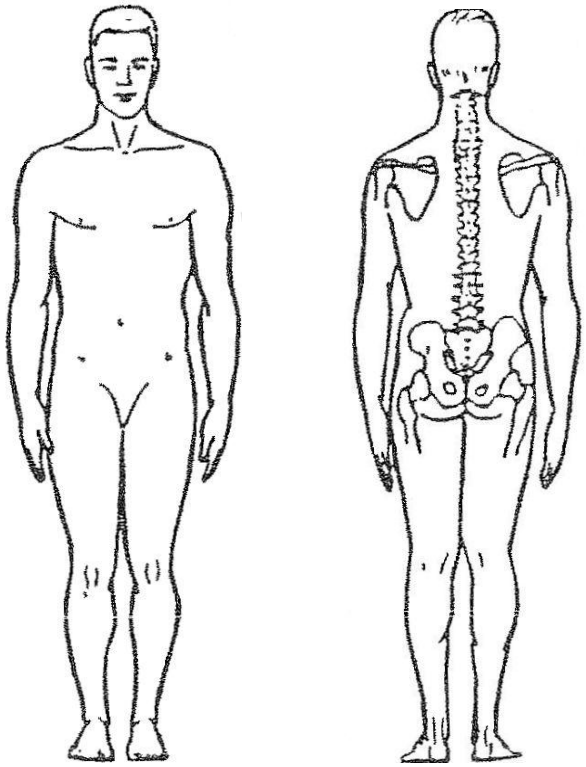
Physician: _____ Phone: _____
Dentist: _____ Phone: _____

Whom may we contact in the case of an emergency?: _____ Phone: _____
Whom may we thank for referring you to us?: _____ Phone: _____

Who is financially responsible for this bill?: _____

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 &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 first time you were aware of this problem?: _____
Have you ever had this problem or similar problem before? If yes, please explain: _____

Have you ever received any treatment for this condition? If yes, where and when, and what were the results?: _____

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

(PLEASE COMPLETE REVERSE SIDE)

Is there anything you do that makes your condition worse?: _____

How has this condition affected your life?

- Home life _____
- Occupational life _____
- Recreational life _____
- 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? _____

_____

ANY MEDICAL DIAGNOSIS OF YOUR COMPLAINT? _____

_____

Any Type of Surgery in Your Life: _____

DRUGS YOU NOW TAKE: ☐ Nerve Pills ☐ Pain Killers ☐ Muscle Relaxers ☐ Anti-inflammatory ☐ Tranquilizers ☐ Insulin

☐ Birth Control Pills ☐ Other (please list) _____

ANY CHIROPRACTOR CONSULTED IN THE PAST? ☐ Yes ☐ No 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. All X-rays remain the property of this clinic, due to privacy act.

Patients Signature: _____ **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 accident, 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 ☐ Driver? ☐ Passenger? ☐ Pedestrian?

If auto accident, 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 a 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

Did you require post-accident hospitalization? ☐ Yes ☐ No

List the extent of the injuries as you know them. _____

_____

CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE 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	

☐ Other Symptoms Not listed 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: _____