# APPLICATION FOR TREATMENT

## PERSONAL INFORMATION

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

Address: _____ City/State/Zip: _____

E-mail Address: _____

Birth Date: __/__/__ Age: _____ Are you Pregnant: ☐ Yes ☐ No

Employer's Name & Address: _____

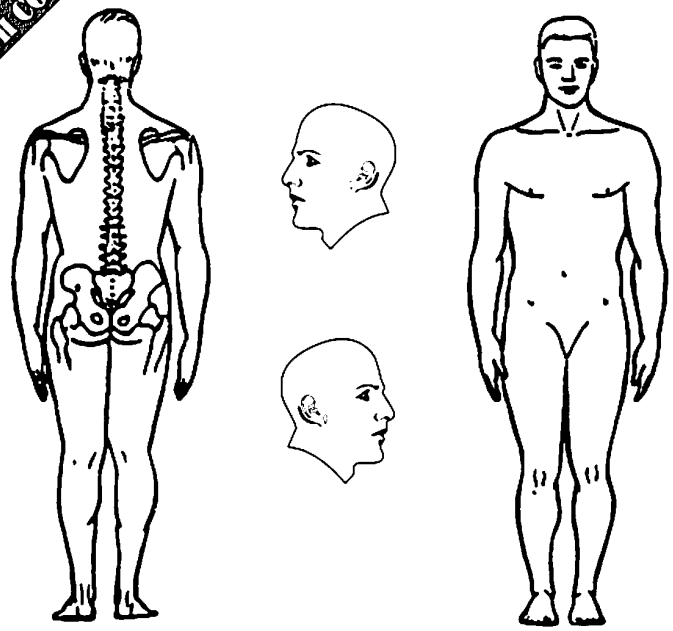
Occupation: _____ Work Phone No.: _____ Home Phone No.: _____

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: _____

☐ Work Activities Effected: _____

Have you missed any work days? ☐ Yes ☐ No If yes, dates missed: _____

☐ Recreational Activities Effected: _____

☐ Rest or Sleep Effected: _____

(Please 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? ☐ 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 approximate 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 a Health Spa
☐ Purchased Vitamins ☐ Purchased Health Foods ☐ 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 or husband: _____

Spouse's Employer: _____ Business Phone: _____

## FINANCIAL RESPONSIBILITY

Who is responsible for your bill? ☐ I am ☐ Spouse (Spouse's Birthdate: ____ /____/ ____)
☐ 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: ____/____/____