APPLICATION FOR TREATMENT

PERSONAL INFORMATION

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

Address: _____ City/State/Zip: _____

E-mail Address: _____

Birth Date: ____/____/____ Age: _____ Are you Pregnant: ❒ Yes ❒ No Cell Phone #: _____

Employer's Name & Address: _____

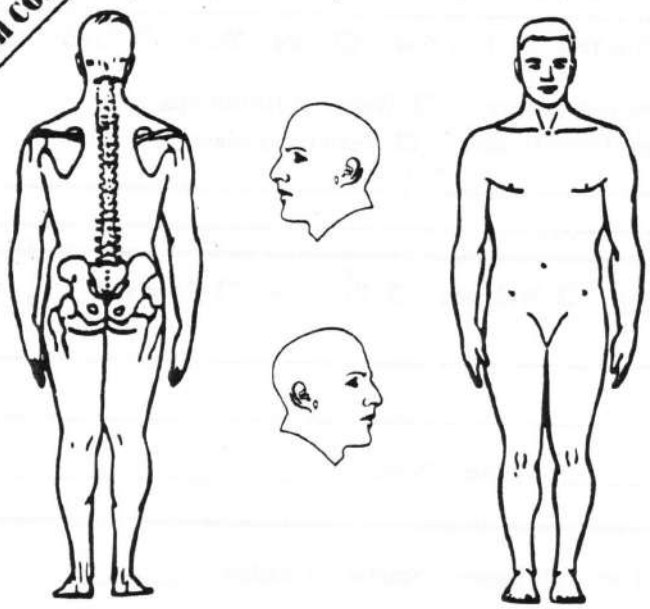
Occupation: _____ Work Phone No.: _____ Home Phone No.: _____

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 _____ Date: ____/____/____