APPLICATION FOR TREATMENT

E-Mail Add:

Please check the type of care desired: ☐ Temporary Relief ☐ Lasting Correction

☐ Check here if you want the Doctor to recommend the best type of care for you.

Date: _____

Name: _____ Date of Birth: _____

Address: _____ City _____ State _____ Zip Code _____

Home Phone Number: _____ Phone at Work: _____

Check if you are: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Name of Husband or Wife: _____ Ages of Children: _____

Where are you or husband/wife employed? _____

Your days off: _____ Referred to our office by: _____

Who is responsible for your bill? ☐ Self ☐ Spouse ☐ Employer ☐ Insurance ☐ Other _____

How Payment will be made:

_____ Cash

_____ Check

Type of Insurance

_____ Workers' Comp.

_____ Credit Card

_____ Health Insurance

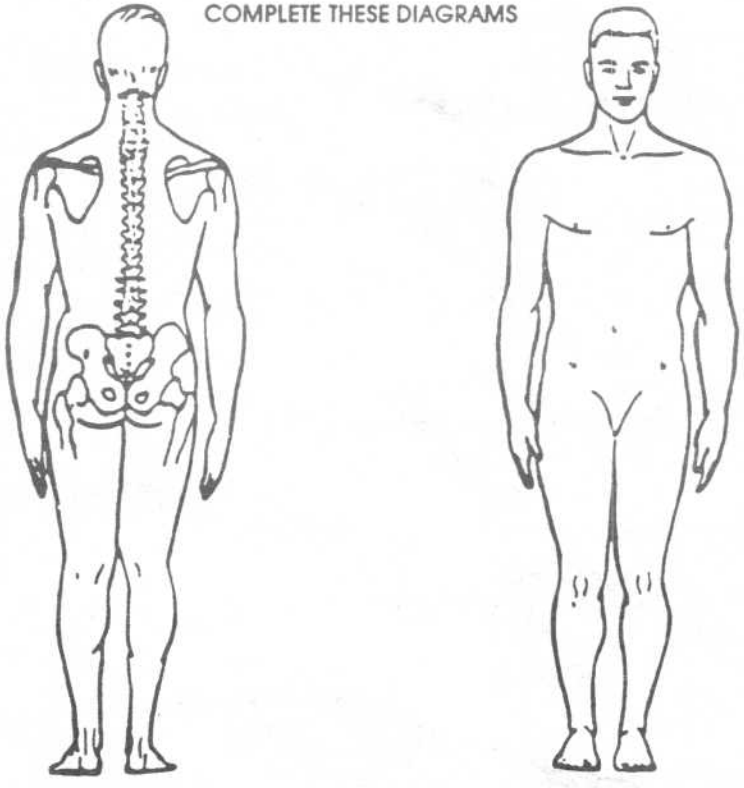
_____ Automobile Ins. Policy

Name of Company and Address _____

_____

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., 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 very 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 your 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?

A. Home life _____

B. Occupational life _____

C. Recreational life _____

D. 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 _____

What surgery has been done? _____

Are you pregnant? ☐ Yes ☐ No

DRUGS YOU NOW TAKE: ☐ Nerve Pills ☐ Pain Killers ☐ Muscle Relaxers ☐ "Pep" Pills ☐ Tranquilizers ☐ Insulin ☐ Birth Control Pills ☐ Other (please list) _____

ANY CHIROPRACTOR CONSULTED IN THE PAST? 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. X-rays remain the property of this clinic.

Patient's Signature: _____ Social Security No. _____ 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 [redacted] an auto collision, 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 collision, 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; List the extent of the injuries as you know them: _____

_____ Did you require post-accident hospitalization? ☐ YES ☐ NO

CHECK SYMPTOMS YOU HAVE NOTICED SINCE 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	☐ _____

Symptoms other than 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 No: _____