Application For Treatment

Today's Date ____/ ____/ _______

It is important that you answer all of the questions that apply to you to the best of your knowledge. If you have any questions or need assistance please let us know.

Last Name:________________________ Name you wish to be called by:_________________

First Name and Initial:__________________________, Date of Birth ___/___/_____, Sex ____

Address: ________________________________, City/State/Zip: _________________________

Mailing Add:______________________________, City/State/Zip: ________________________

Home Phone: ___________________________, Message Phone: _______________________

If no home phone, please give a number where we can leave a message or contact your family)

Cell Phone: _____________________, E-Mail Address: _______________________________

Social Security #___________________, Driver's Lic. #______________________State_____

Height__________, Weight_________, Marital Status [ ] S [ ] M [ ] D [ ] W

Name and address of nearest relative not living with you: ______________________________

____

Name and address of a close friend: ____

____

I prefer to handle my account : [ ] Insurance [ ] Cash/Check [ ] Credit Card

If a person other than the patient is responsible for payment of the account, please give that person's name address and phone number ;

____

____

Patient's or Responsible Party's Occupation : ____

Work Phone ; _____________________, Employed by ; _______________________________

Spouse's Name ; __________________, Spouse's Occupation; ________________________

Spouse's Employer; ____________________________, Work Phone : ___________________

Tell us how you heard about our office: ____

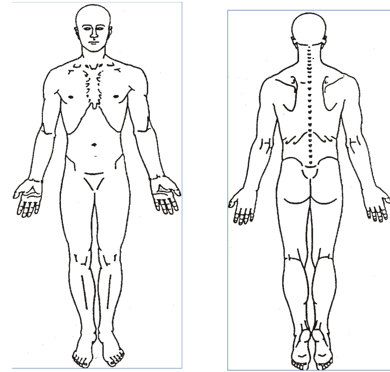
(If a friend or family member referred you, give us their name and address so we may thank them for referring our services.)

Fees are payable at the time of service, (X-rays, exams, treatments, etc.), X-rays remain the property of this clinic.

All Information Is Correct To The Best Of My Knowledge.

Signature : ____

Please describe your pain in your own words. If you are in pain, indicate on the figures at the right exactly where the pain is located.



____
____
____
____
____

How long have you had this problem? _______________

Is this visit due to an accident? If so, tell us what type, (auto, work, etc.) And when it occured. Please describe in your own words how it happened.

____
____

Are you pregnant? [ ] Yes [ ] No

List all medications you are now taking : ____
____

List any allergies; ____

Are you wearing : [ ] Heel lifts [ ] Sole lifts [ ] Inner soles [ ] Arch support [ ] Dentures [ ] Artificial limb

To your knowledge, have you any metal in your body? (Ex: surgical wire, implants, metal fragments that haven't been removed)? [ ] Yes [ ] No

Have you been in an auto accident? [ ] past yr [ ] 5 yrs [ ] Over 5 yrs [ ] Never

Any other personal injury or accident? [ ] 1 yr [ ] 5 yrs [ ] Over 5 yrs [ ] Never

Briefly describe : ____
____

Have you been treated for a spinal disorder? [ ] Yes [ ] No

Have you ever had chiropractic care before? [ ] Yes [ ] No

If yes : Name of Doctor: ____

Treated for : ____

Were you satisfied with care? [ ] Yes [ ] No

Have you ever: Been knocked unconscious? [ ] Yes [ ] No

Used a cane, crutch, etc. ? [ ] Yes [ ] No

Had a fractured bone ? [ ] Yes [ ] No

Been hospitalized for other than surgery ? [ ] Yes [ ] No

List surgical operations you have had and approximately when: _________________________
____

Do you take vitamins ? [ ] Yes [ ] No

Do you feel you may need vitamins ? [ ] Yes [ ] No

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