TREATMENT APPLICATION

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: ____________________ Cell Phone # ____________________

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

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

Where are you or husband/wife employed? ____________________

E-Mail: ____________________ Referred to our office by: ____________________

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

How Payment will be made: Type of Insurance

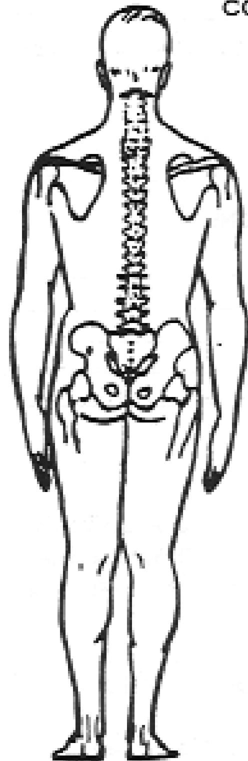
______ Cash ______ Workers' Comp. ______ Health Insurance

______ Check ______ Automobile Ins. Policy

Name of Company and Address ____________________

____

COMPLETE THESE DIAGRAMS



MAJOR COMPLAINT
(Please describe only your major problem)

____

If you are in pain, please mark the exact location of your pain on the diagram above. 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.

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)

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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 not 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.: ______