APPLICATION FOR TREATMENT

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

Date: ____/____/20____

Name: ____Date of Birth: ___/___/____

Address: ____ City: _____________ State: ______ Zip Code: ___________

Ph: (   )_______-_________ Cell: (   )_______-_________ Business: (   )_______-_________

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Name of Spouse: ___________________________________ Ages of Children: _____________________

Employer: __________________________________ Spouse's Employer: ________________________________

Your days off: _______________________________ Referred to our office by: _____________________________

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

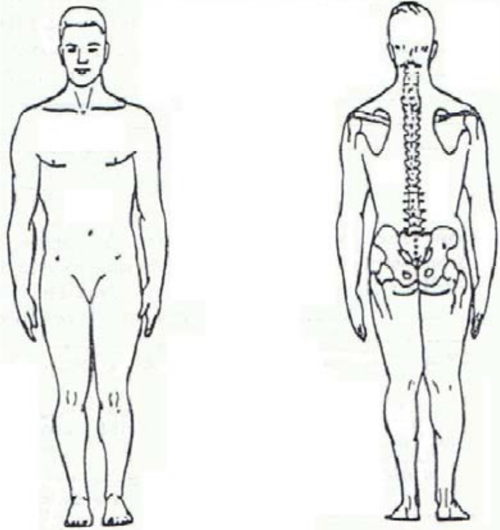
How payment will be made: (check all that apply)

__________ Cash __________Workers' Comp __________ Health Insurance

__________ Check __________ Credit Card __________ Auto Insurance Policy

---

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.



MAJOR COMPLAINT

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

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?

____

____

Has this problem been getting better, worse or staying the same?

____

____

(PLEASE COMPLETE REVERSE)

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 ____

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: ______________________________ Ph: ______________________
Dates consulted: _______________________________ For what problem? _____________________________________

NOTE: 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: ______________________ City: ______________________
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 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	___Cold Hands
___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	___Other

Symptoms other than above: ____
Have you lost any days of work? ___ YES ___ NO If yes, 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. ______________________________