APPLICATION FOR TREATMENT

Date_____

Name_____ Age_____ Birthdate_____
Address_____ City_____ State_____ ZIP Code_____
Home Phone Number_____ Phone at Work_____ Cell Phone_____
Referred to our office by_____ E-Mail Address_____
Check if you are: Married____ Single____ Widowed____ Divorced____ Separated____
Employer_____ Occupation_____
How and when did symptoms first occur?_____
List any other doctors seen for these problems_____
Have you lost any days of work? Yes____ No____ Dates_____
Have you had similar symptoms or injuries before? Yes____ No____ If yes, explain_____
_____
Who is responsible for your bill? Self____ Spouse____ Employer____ Insurance____ Other_____
How payment will be made:
____ Cash ____ Worker's Compensation ____ Health Insurance _____ Check ____ Credit Card ___ Automobile Ins. Policy

Who to contact in case of an emergency?_____

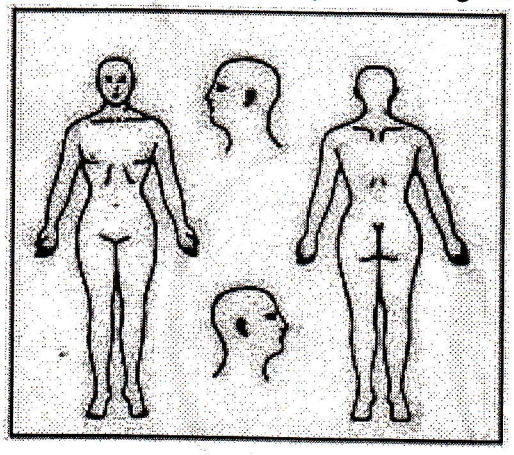
PAST HISTORY

Has a physician treated you for any health condition in the last year? Yes____ No____
If yes, explain:_____
_____
Have you or any relative received Chiropractic treatment previously? Yes____ No____ If yes, explain_____
_____
_____
List all drugs or medication that you have used recently (i.e., aspirin, sleeping pills, birth control pills, etc.)_____
_____

FAMILY HISTORY

Name of wife or husband_____
Spouse's Employer_____ Business Phone_____
You're Nearest Relative_____
Relative's Address_____

Please mark your areas of pain on the figures below._____



List the conditions that you are most interested in getting corrected. List in order of importance:
1._____
2._____
3._____
4._____

What functions are you unable to perform or induce pain upon performance? List in order of severity. (Example: sitting, walking, bending, lying down, etc.)
1._____
2._____
3._____
4._____

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.
I HEREBY GIVE PERMISSION FOR TREATMENT.

Signature of Patient_____ Social Security Number_____