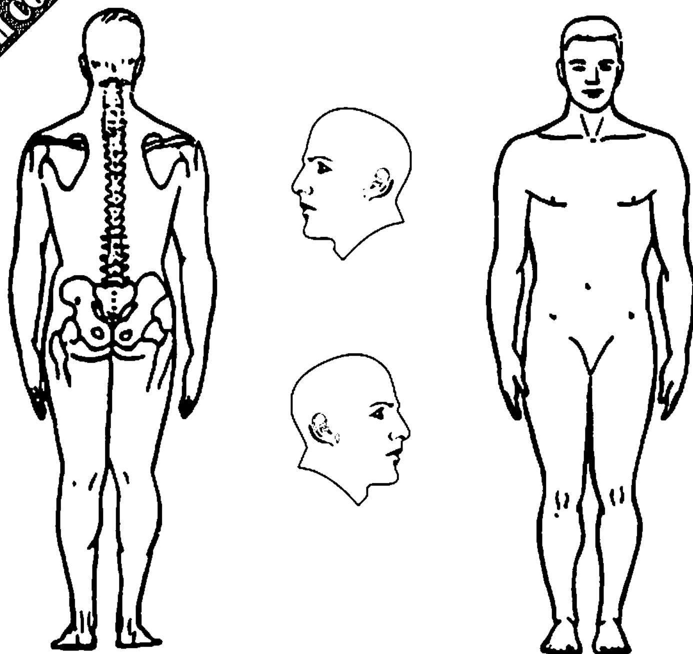
APPLICATION FOR TREATMENT

PERSONAL INFORMATION

Name: ______________________ Today's Date: ___/___/___
Address: ______________________ City/State/Zip: ______________________
E-mail Address: ______________________
Birth Date: ___/___/___ Age: ________ Are you Pregnant: ☐ Yes ☐ No
Employer's Name & Address: ______________________
Occupation: ______________ Work Phone No.: ______________ Home Phone No.: ______________
Who referred you to our office: ______________________
What type of care do you desire: ☐ Temporary Relief ☐ Lasting Correction ☐ Best Care Possible

CURRENT HEALTH CONDITION

Please circle the exact location of any pain you are experiencing. Then describe the type of pain, i.e. dull, sharp, constant, on & off, etc.



In order of importance, list the health problems you are most interested in getting corrected:
1) ______________________
2) ______________________
3) ______________________
4) ______________________
5) ______________________

In order of severity, list those body functions that you are unable to perform, or that produce pain upon performance, i.e. walking, sitting, bending, etc.
1) ______________________
2) ______________________
3) ______________________
4) ______________________
5) ______________________

When was the first time you noticed this problem:
____
____

Describe any accidents, falls, injuries, sudden movements, etc. that may have caused your problem: ______________________
____

Have you had any similar health problems or injuries before? ☐ Yes ☐ No If yes, please explain: ______________________
____

Names of all other doctors you have seen for this problem: ______________________
____

Diagnosis and type of treatment you received (please include where and when you received treatment, and the results):
____
____

Has your health problem been: ☐ Improving ☐ Worsening ☐ Staying the Same
Please describe anything you do that improves your condition, or worsens it: ______________________
____

Please check off and describe how this problem interferes with your work and/or personal life:
☐ Home Activities Effected: ______________________
☐ Work Activities Effected: ______________________
Have you missed any work days? ☐ Yes ☐ No If yes, dates missed: ______________________
☐ Recreational Activities Effected: ______________________
☐ Rest or Sleep Effected: ______________________

(Please complete reverse side.)

PREVIOUS HEALTH HISTORY

During the last year, has a doctor treated you for any health problem? ☐ Yes ☐ No
If yes, please explain: ______________________________

____

____

Have you ever received Chiropractic care? ☐ Yes ☐ No If yes, please list the doctor's name, location of office and for what problems: ______________________________

____

____

Please check off the drugs you are now taking: ☐ Pain Killers ☐ Muscle Relaxers ☐ Anti-inflammatory
☐ Blood Pressure Medication ☐ Insulin ☐ Birth Control Pills ☐ Tranquilizers ☐ Diet Pills
☐ Nerve Medication ☐ Sleeping Pills ☐ Anti-depressants ☐ Other (please list): ______________

____

List the approximate dates of any accidents, operations or serious injuries (including broken bones) you have had: _____

____

____

If you have been in an automobile accident, when? ☐ This Year ☐ Last Year ☐ Past 5 Years ☐ Over 5 Years

Please check off the following that apply to you within the past 2 years: ☐ Went to a Health Spa
☐ Purchased Vitamins ☐ Purchased Health Foods ☐ Received a Massage
Please explain why you choose to do any of the above: ______________________________

____

FAMILY HEALTH HISTORY

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

Names & Ages of Children: ______________________________

Name of wife or husband: ______________________________

Spouse's Employer: ______________________ Business Phone: ______________

FINANCIAL RESPONSIBILITY

Who is responsible for your bill? ☐ I am ☐ Spouse (Spouse's Birthdate: ____ /_____/ _____)
☐ My Employer ☐ Insurance ☐ Other: ______________
Type of Insurance: ☐ Worker's Comp. ☐ Health ☐ Automobile
Insurance Company's Name & Address: ______________________________

____

If you are responsible for your health care fees, payment will be made by: ☐ Cash ☐ Check ☐ Credit Card

Your fees are due and payable at the time examinations, X-rays, and treatments are received, unless other arrangements have been made in advance. X-rays remain property of this clinic.

I, the undersigned, hereby give permission for treatment.

Patient's Signature ______________________ Social Security No: ______________________ Date: ____/____/_____

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PATIENT NAME: ______________________

DATE: ______________________

PATIENT HISTORY

FAMILY HISTORY

Age(s) of: Father_____ Mother______ Children______________________

Please indicate who in your family has suffered from, or currently has any of the following diseases:
TB_________ Mental Disorder_________ Diabetes_________ Asthma_________ Liver Disease_________
High Blood Pressure __________ Heart Disease__________ Lung Disease__________ Arthritis__________
Cancer (Indicate Type) ______________________

PERSONAL HISTORY

Please indicate if you've had any of the following childhood diseases:
Measles_____ Mumps_____ Chicken Pox_____ Others______________________

Have you had any (please list):
Unusual childhood illnesses? ______________________
Adult illnesses or conditions? ______________________
Surgeries? ______________________
Fractures? ______________________

Do you smoke? ☐ Yes ☐ Never Have ☐ Smoked for _____ years. Quit date: ________
Are you pregnant? ☐ Yes ☐ No Date of last period: ______________________

List any medication or supplements you are currently taking: ______________________

____

Date of Last Physical: __________ Findings: ______________________
Date of Last Chiropractic Exam: __________ Findings: ______________________

Please describe any recent falls or injuries, including date(s): ______________________

____

Please describe your major symptoms or health problems, and when you first started experiencing them:
1) ______________________ 4) ______________________
2) ______________________ 5) ______________________
3) ______________________ 6) ______________________

Are any of your symptoms aggravated or worsened by certain everyday activities? If yes, please explain:

____

____

Have you ever been disabled? ☐ Yes, from ________ to ________ ☐ No
Have you ever been hospitalized? ☐ Yes, from ________ to ________ ☐ No

Please check off any of the following symptoms that you are presently suffering from:

☐ Headaches	☐ Insomnia	☐ Loss of Appetite	☐ Low Energy
☐ Migraines	☐ Constipation	☐ Hot Flashes	☐ Labored Breathing
☐ Dizziness	☐ Diarrhea	☐ Impotency	☐ Swelling
☐ Neck Pain	☐ Excessive Gas	☐ Overactive Bladder	☐ Sinusitis
☐ Blurred Vision	☐ Indigestion/Heartburn	☐ Urination Discomfort	☐ Anxiety
☐ Fainting	☐ Arm Pain/Numbness	☐ Shoulder Pain	☐ Loss of Hearing
☐ Memory Loss	☐ Leg Pain/Numbness	☐ Heart Palpitations	☐ Night Pain

☐ Other: ______________________

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