

Application for Treatment

Name: _____ Date of Birth ____/____/____ S.S. # ____-____-____

Address: _____ City: _____ State: ____ Zip: _____

Phone: Home: _____ Work: _____ Cell: _____

Email Address: _____ Is it OK to send you our monthly e-newsletter? Yes No

Name of your Employer: _____

Physical requirements of your job: _____

Check if you are: Married Single Widowed Divorced Separated

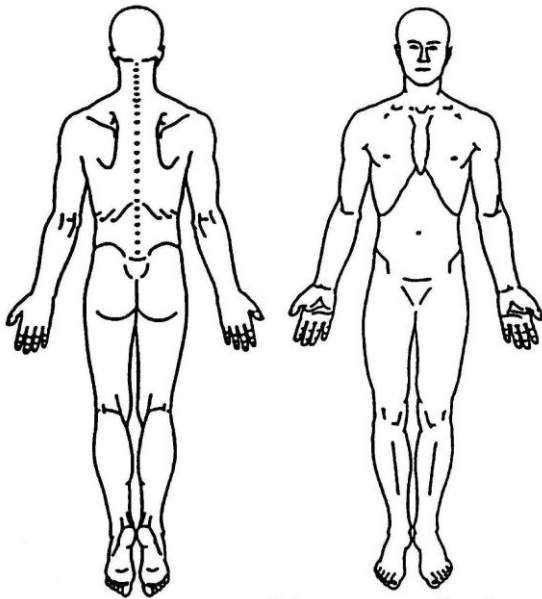
Name of Spouse/Responsible Party: _____ Relationship to Patient: _____

Primary Care Physician: _____ Telephone: _____

Address of Physician: _____

Referred to our office by: _____

Please mark the location/s of your pain or numbness on the diagram below, and number from most bothersome to least.



Briefly describe your major complaint/s:

First time you remember having this problem?

MEDICAL HISTORY:

Was there a specific activity that started your pain? _____

What seems to make your condition worse? _____

What seems to help? _____

What have you tried so far that has *not* worked? _____

When the pain is at its worst, how does it feel? _____

When the pain is at its worst, how much older do you feel than your actual age? _____

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

When it is at its worst, how does it affect you at work? _____

When it is at its worst, how does it affect you at home? _____

What do you like to do for fun? (hobbies, exercise, etc.) _____

How has this problem affected your ability to do these things? _____

How has this problem been affecting your sleep? _____

Have you ever been injured in an auto accident (sore afterwards)? Yes No

If yes, when, and what were your injuries? _____

Please list any other accidents or physical traumas you have had during your life, including childhood: _____

Please list any past surgeries: _____

Do you suffer from: Headaches Sinus problems Digestive Problems Painful Menstruation

Arthritis Loss of smell/taste

Any other health problems? _____

Is there a possibility that you are now pregnant? Yes No

Medications you currently take: _____

Vitamins/Supplement you currently take: _____

Have you been treated previously by a chiropractor? Yes No

If yes, by whom and what were your results?

Do you have any questions/concerns? _____

I understand that fees are payable at the time treatment is received unless other arrangements are made in advance.

Signature: _____ Today's Date: _____