Application for Treatment

Please Print Give complete answers to all questions. This information is confidential. Your input will help determine if chiropractic can help you.

Patient Information

Last Name	First	Middle	Today's Date	Case No.

Address	City	State	Zip

Social Security	Age	Birth Date	Sex	Marital Status	No. of Children	Home Phone

Employer	Address	Business Phone

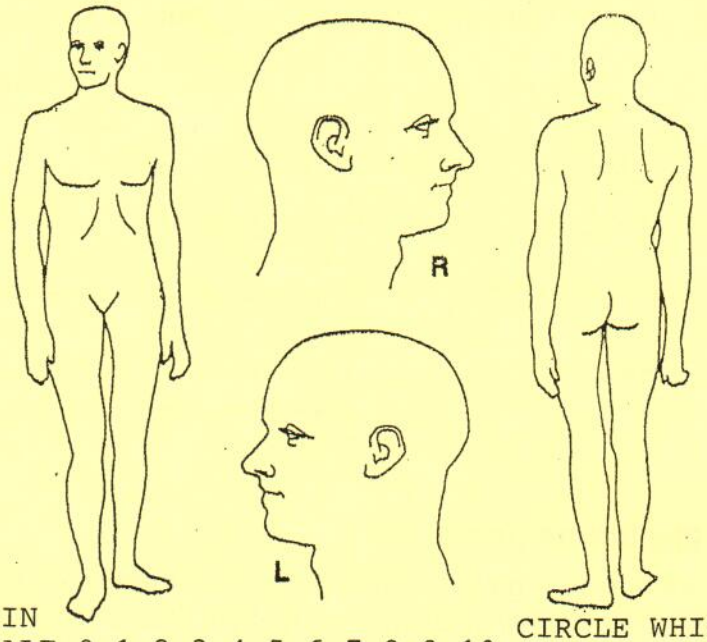
Occupation	Who refered you to us	Address

NAME OF PERSON TO CONTACT OTHER THAN ABOVE _____ Phone _____
(not living in your home)

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 and on, when standing, when sitting, etc.

COMPLETE THESE DIAGRAMS

Mark areas of pain resulting from this accident on figures below



PAIN SCALE 0 1 2 3 4 5 6 7 8 9 10 CIRCLE WHICH APPLIES
BEST WORST

MAJOR COMPLAINT

(Please describe only your major problem)

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)

Is there anything you do that makes your condition worse? _____

_____

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 Allergies: ___Drug Allergy_____

___Other_____None_____

Medications you now take: _____

_____

_____

ANY CHIROPRACTOR CONSULTED IN THE PAST? Name: _____

Dates consulted: _____ For what problem? _____

Smoking Status: ___Currently _____Amount Per Day

___Former _____Quit Date ___Never

Ethnicity: ___Hispanic/Latino ___Not Hispanic/Latino ___Declined

Language: ___English ___Spanish ___Other

Race: ___Black/African American ___White ___Asian

___American Indian or Alaska Native ___Other ___Declined

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

How Payment will be made:

_____ Cash

_____ Check

Type of Insurance

_____ Workers' Comp.

_____Credit Card

_____ Health Insurance

_____ Automobile Ins. Policy

STANDARD BILLING PROCEDURE

In most cases chiropractic care is covered by insurance. We will gladly submit forms to your carrier. We ask that you pay any deductible or uncovered amount to your office. We will gladly make payment arrangements with you concerning the amount which you are paying. Please be advised that you are responsible for your bill regardless of the fact that you may have insurance coverage.

I have read the foregoing information and hereby agree to said procedures.

Patient's signature

(If a minor, parent's or guardian's signature _____ Date _____

Office Use *(Do not write below here)*