APPLICATION FOR TREATMENT

Date: _____

Name: _____ Date of Birth: _____

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

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email Address: _____

O Married O Single O Widowed O Divorced O Separated SS# _____

Employer: _____

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

Name of Spouse: _____ Date of Birth: _____

Spouse SS#: _____ Emergency Contact: _____

Name of Primary Care Physician: _____

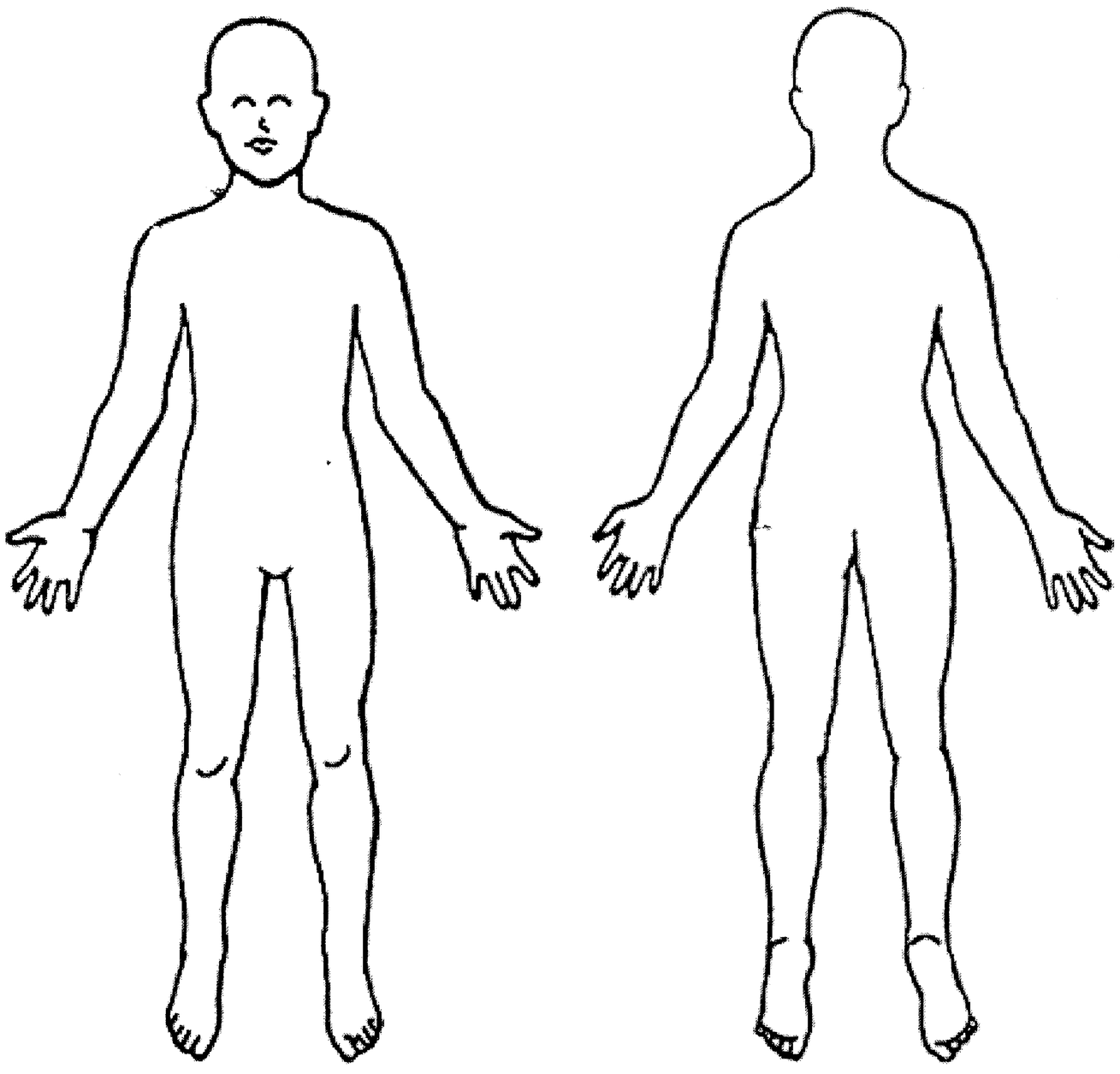
Referred to our office by: _____

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

Name of Insurance Company and Address: _____

_____

Please mark the areas you are having pain on the diagrams below:



MAJOR COMPLAINT

(Please describe major problems only)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

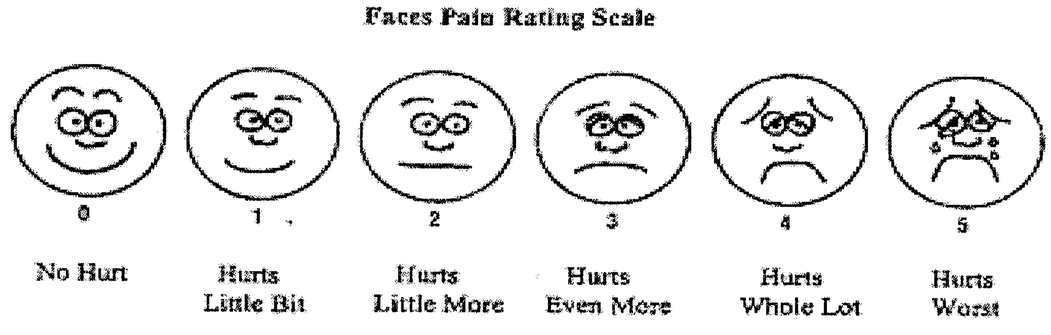
_____

_____

_____

_____

Please circle your pain level below:



How did this condition develop? _____

_____

_____

_____

When was the 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 treatment for this condition? _____
If YES, where and when and the results? _____

_____

Has this problem been getting better, worse or staying the same? _____
Is there anything you do that makes your condition worse? _____

_____

_____

Have you ever been in an automobile accident? O Past Year O Past 5 Years O Over 5 years O Never
Any accidents, falls, etc that might have caused your problem?

_____

_____

_____

Have you had any surgeries? If YES please list: _____

_____

Are you pregnant? O YES O NO

Please check if you have any of the following:

O Vascular Disease O Metal Implants O Diabetes
O Pacemaker O Malignancy

Please list medications and dosage: _____

_____

Any chiropractor consulted in the past? Name: _____
Dates consulted: _____
For what condition: _____

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 : _____ Date: _____

Family History

Fill in information about your family

Relation	Age	Health	Deceased	Cause of Death
Father				
Mother				
Brothers				
Sisters				

Check if your blood relatives had any of:

	Disease	Relationship
	Arthritis	
	Asthma, Hay Fever	
	Cancer	
	Chemical Depend.	
	Diabetes	
	Heart Diseas/Stroke	
	High Blood Pressure	
	Kidney Disease	
	Tuberculosis	

Hospitalizations

Year	Hospital	Reason for stay & outcome

Have you ever had a blood transfusion ☐ Yes ☐ No

If yes, please five approximate dates_____

Serious Illness / Injuries	Date	Outcome

Pregnancies

Year	Sex	Complications

Health Habits

Check (√) which substances you use and describe how much you use.

	Caffeine	
	Tobacco	
	Drugs	
	Other	

Occupational

Check (√) if your work exposes you to:

	Stress
	Heavy Lifting
	Hazardous Substances
	Other:
Occupation:	

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature _____ Date _____

Reviewed By _____ Date _____

Patient Name _____ Date _____

Age _____ Birthdate _____ Date of last physical examination _____

What is your reason for your visit today? _____

Symptoms Please check (√) symptoms you currently have or have had in the past year.

GENERAL

□Chills
□Depression
□Dizziness
□Fainting
□Fever
□Forgetfulness
□Headache
□Loss of Sleep
□Loss of Weight
□Nervousness
□Numbness
□Sweats

MUSCLE/JOINT/BONE

Pain, weakness, numbness in :

□Arms □Hips
□Back □Legs
□Feet □Neck
□Hands □Shoulders

GENITO-URINARY

□Blood in urine
□Frequent Urination
□Lack of bladder control
□Painful Urination

GASTROINTESTINAL

□Appetite Poor
□Bloating
□Bowel Changes
□Constipation
□Diarrhea
□Excessive Hunger
□Excessive Thirst
□Gas
□Hemorrhoids
□Indigestion
□Nausea
□Rectal Bleeding
□Stomach Pain
□Vomiting
□Vomiting Blood

CARDIOVASCULAR

□Chest Pain
□High Blood Pressure
□Irregular heart beat
□Low Blood Pressure
□Poor Circulation
□Rapid Heart beat
□Swelling of Ankles

EYE,EARS,NOSE,THROAT

□Blurred Vision
□Bleeding gums
□Crossed Eyes
□Difficulty Swallowing
□Double Vision
□Earache
□Ear Discharge
□Hay Fever
□Hoarseness
□Loss of hearing
□Nosebleeds
□Persistent cough
□Ringing ears
□Sinus Problems
□Vision Flashes
□Vision Halos

SKIN

□Bruise easily
□Hives
□Itching
□Change in moles
□Rash
□Sores that won't heal

MEN only

□Breast lump
□Erection Difficulty
□Lump in Testicles
□Penis Discharge
□Sore on penis
□Other

WOMEN only

□Abnormal Pap
□Midcycle bleed
□Breast lump
□Menstrual Pain
□Hot flashes
□Nipple Discharge
□Painful Intercourse
□Vaginal Discharge
□ Other

Date of last period

_____

Date of last pap

_____

Mammogram_____

Pregnant?_____

# of children_____

Conditions Please check (√) symptoms you current have or have had in the past

□AIDS
□Alcoholism
□Anemia
□Anorexia
□Appendicitis
□Arthritis
□Asthma
□Bleeding Disorder
□Breast lump
□Bronchitis
□Bulimia
□Cancer
□Cataracts
□Chemical Dependency
□Chicken Pox
□Diabetes
□Emphysema
□Epilepsy
□Glaucoma
□Goiter
□Gonorrhea
□Gout
□Heart Disease
□Hepatitis
□Hernia
□Herpes
□High Cholesterol
□HIV positive
□Kidney Disease
□Liver Disease
□Measles
□Migraine
□Miscarriage
□Mononucleosis
□Multiple Sclerosis
□Mumps
□Pacemaker
□Pneumonia
□Polio
□Prostrate Problem
□Psychiatric Care
□Rheumatic Fever
□Scarlet Fever
□Stroke
□Suicide Attempt
□Thyroid Problems
□Tonsillitis
□Tuberculosis
□Typhoid Fever
□Ulcers
□Vaginal Infections
□Venereal Disease

Medications List medications you are currently taking

_____
_____
_____
_____
_____
_____

Allergies

_____
_____
_____
_____
_____
_____

PLEASE TURN OVER AND COMPLETE OTHER SIDE