## APPLICATION FOR CHIROPRACTIC TREATMENT

Please check the type of care desired: ❍Temporary Relief ❍Lasting Correction
❍I want the doctor to select the type of care he feels is best for me.

Date________________________ Home Phone______________________
Cell Phone______________________
Email______________________@________

Name______________________ Age_______ Birth Date______________
Address______________________ City/State/Zip______________________
Marital Status: S M D W SSN:______________ Driver's License______________ State________
Employer______________________ Occupation______________________
Address______________________ Office Phone______________________
Name of Spouse______________________ Occupation______________________
Spouse's Employer______________________ Office Phone______________________
Patient's Nearest Relative______________________ Phone______________________
Address______________________ City/State/Zip______________________
Emergency Contact______________________ Phone______________________

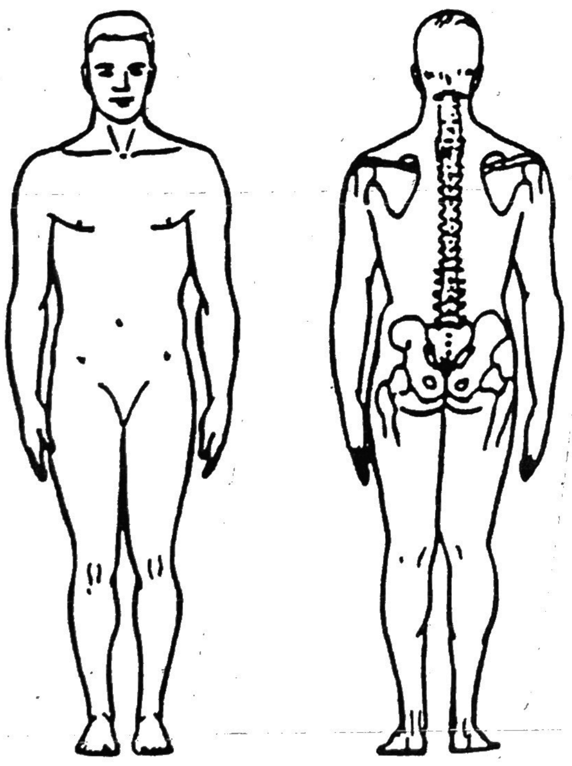
**Who is responsible for your bill?** ❍Self ❍Spouse ❍Parent (if patient is a minor) ❍Insurance ❍Employer
❍Other (please specify) ______________________

**How Payment will be made:** ❍Cash ❍Check ❍Insurance ❍Worker's Comp (**must** have referral)

Insurance Co______________________ Contact Phone______________________
Address______________________ City/State/Zip______________________
Subscriber: ❍Self ❍Spouse ❍Parent ❍Other______________________
ID#______________ Group#______________ Effective Date______________

**Have you ever been in an automobile accident?** ❍Never ❍YES: ❍Past year ❍Past 5 years ❍Over 5 years ago

**PLEASE MARK THE EXACT LOCATION OF YOUR PAIN ON THE FIGURE BELOW.**



**MARK ALL THAT APPLY:**

❍ NECK PAIN ❍ STIFF NECK ❍ BACK PAIN
❍ CHEST PAIN ❍ HEADACHE ❍ MIGRAINE
❍ SLEEPING PROBLEMS ❍ RINGING IN EARS
❍ NAUSEA/UPSET STOMACH ❍ DIZZINESS
❍ DEPRESSION ❍ ANXIETY ❍ TENSION
❍ EYES, SENSITIVE TO LIGHT ❍ FAINTING SPELLS
❍ FLUSHED FACE ❍ IRRITABILITY ❍ FATIGUE
❍ INSOMNIA ❍ COLD: FEET, HANDS, SWEATS
❍ PINS & NEEDLES IN ARMS/LEGS ❍ FEVER
❍ CONSTIPATION ❍ NUMBNESS: FINGERS, TOES
❍ LOSS OF: MEMORY, HEARING, SMELL, TASTE
❍ ______________________

**Have you ever suffered from:**

❍ Anemia ❍ Hemorrhoids
❍ Arthritis ❍ Liver Trouble
❍ Asthma ❍ Rheumatic Fever
❍ Cancer ❍ Sinus Trouble
❍ Diabetes ❍ Stomach Ulcers
❍ Heart Trouble ❍ Tuberculosis
❍ ______________________

Date of Last Physical Examination______________________
**Date symptoms began**______________________ How?______________________
Have you ever had this problem or a similar problem before? If yes, please explain:______________________
______________________

~PLEASE COMPLETE REVERSE SIDE~

Any accidents, falls, etc, that might have caused this problem? If yes, please explain:______________________________

______________________________

Have you ever received any treatment for this condition? Where and when? What were your results?______________________________

______________________________

Has this problem been getting better, worse, or staying the same?______________________________
Is there anything you do that makes your condition worse?______________________________
How has this condition affected your life in the following areas:
A) Home life______________________________
B) Occupation______________________________
C) Recreation______________________________
D) Rest & Sleep______________________________

Previous Surgeries: Procedure______________________________ Year______________
Procedure______________________________ Year______________
Procedure______________________________ Year______________

Have you previously consulted any Chiropractor in the past?
O No O Yes: Name______________________________ Dates______________
For what problem(s) ______________________________

Medicine you currently take: O Birth control pills O Painkillers O Muscle Relaxers O Insulin O Ibuprofen O Acetaminophen O "Pep" Pills O Tranquilizers O **OTHER**: ______________________________

**ALL FEES FOR SERVICES RENDERED, INCLUDING X-RAYS, EXAMINATIONS, TREATMENTS & THERAPIES, ARE DUE AT THE TIME OF YOUR VISIT, UNLESS OTHER ARRANGEMENTS ARE MADE IN ADVANCE. X-RAYS REMAIN THE PROPERTY OF THE OFFICE.**

**Patient's Signature:** ______________________________ **Date:** ______________

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**IF YOUR INJURY IS ACCIDENTAL, PLEASE COMPLETE THE FOLLOWING QUESTIONS:**

Type: O Auto Collision O On-the-Job Injury O Other: ______________________________
Date of accident: ______________ Hour: ______AM ______PM Location: ______________________________

Accident reported to foreman or employer? O YES O NO
Did they recommend care at our office? O YES O NO

If not an auto accident, please describe the circumstances: ______________________________

______________________________

______________________________

If auto accident...
Were you: O Driver O Passenger O Pedestrian
Struck from: O Front O Rear O Left Side O Right Side O Parked
Your vehicle: O Was struck O Struck other(s) O Not Sure
Received Citation: O You O Other(s) O Not Sure
Hospitalized: O You O Other(s)
Have you lost any days of work due to this accident? O NO O YES Dates: ______________________________

**Have you consulted or retained an attorney regarding the above accident?** O NO O YES

Attorney: ______________________ Address: ______________________ Phone: ______________

**YOUR** Insurance Co: ______________________________ Policy ID#:______________________
Address______________________________ City/State/Zip______________________
Contact Person______________________________ Phone ______________ Ext________

**Responsible Party**: ______________________________ Insurance Co: ______________________
Address______________________________ City/State/Zip______________________
Claim #: ______________________________ Policy ID#______________________
Case Adjuster______________________________ Phone ______________ Ext________