APPLICATION FOR TREATMENT

Please check the type of care desired: ☐ Temporary Relief ☐ Lasting Correction
☐ Check here if you want the Doctor to select the type of care he feels is best for you.

Date:_____

Name:_____ Date of Birth:_____

Address:_____ City_____State:_____ Zip Code:_____

Home /CellPhone Number:_____ Phone at Work:_____

Check if you are: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Name of Husband or Wife: _____ Ages of Children:_____

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

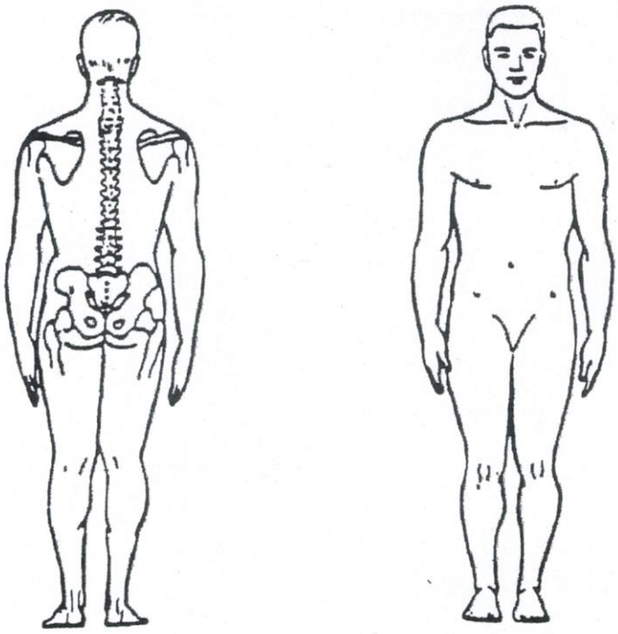
How will payment be made?

_____ Cash _____ Worker's Comp. _____ Health Insurance

_____ Check _____ Credit Card _____ Automobile Insurance Policy

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 & on, when standing, sitting, etc.

COMPLETE THESE DIAGRAMS



COMPLAINT(S):

How did this condition develop? (What caused it? How did it start?)_____

When was the very first time you were aware of this problem?_____

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

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?_____

(Please complete on reverse side)

Has this condition caused you loss of normal activities?

A. Home_____
B. Occupation:_____
C. Recreation:_____
D. Rest and sleep_____

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?_____

ANY CHIROPRACTOR CONSULTED IN THE PAST?_____

Dates consulted_____ For what problem? _____

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 the clinic.

Patient's Signature:_____

Date:_____