Application for Treatment / Update

Date_____

Name _____SS No_____ Date of Birth_____ Age_____

Address_____ City_____ State_____ Zip_____

Home Phone Number_____ Work Phone Number_____

Cell Phone Number_____ E-mail Address: _____

Circle: Married Single Widowed Divorced Separated

Name of Employer_____ Ages of Children_____

Insured's Name_____ Insured's Date of Birth_____

Insured's Employer_____ How Did You Hear About Us? _____

Who Is Responsible For Your Bill? Self Spouse Parent Health Insurance Other

MAJOR COMPLAINT

Please describe your major complaint and rate pain from 0-10, 10 the worst pain and 0 no pain.
(Ex. Sharp pain, numbness, weakness, constant pain)

Headaches: 0-10 _____

_____

Neck Pain: 0-10 _____

_____

Mid Back Pain: 0-10 _____

_____

Low Back Pain: 0-10 _____

_____

Pain in Arms or Legs: 0-10 _____

_____

_____

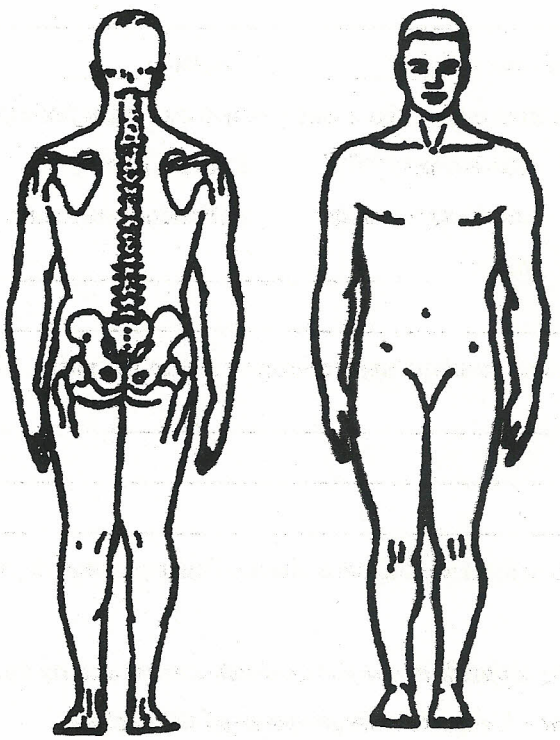
Other Areas (shoulder, hand, knee, ankle, feet): 0-10 _

_____

_____

COMPLETE THESE DIAGRAMS

Please circle the location of your pain on the diagram



Pain is worse: In the Morning In the Evening Sitting Lying Down Other_____

_____

How did this condition develop? _____

_____

_____

When were you first aware of this problem? _____

Has this problem been Getting better Getting worse Staying the same

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

_____

What area of your life does this condition affect? Home Occupational Recreational Rest and Sleep

Is there any medical diagnosis of your current condition? _____

_____

Have you ever experienced this problem before? Yes No If yes, please explain_____

_____

Is there any past or previous injuries or conditions that may contribute to your current problems? (Ex. Auto collision, slip and fall, etc.) Yes No If yes, please explain below:

(a) Describe the accident or injury _____

_____

(b) How long ago_____

(c) Any other condition or injury you have previously had that could contribute_____

_____

Have you had any past surgeries? Yes No If yes, please explain_____

_____

What is your Height _____ Weight _____

Please circle any medications you are currently taking:

Anti-Anxiety Pills	Pain Killers	Muscle Relaxers	Blood Pressure Medication
Anti-Depressants	Diabetic Medication	Anti-Inflammatory	Weight Loss Medication

Other: _____

_____

Have you consulted any chiropractors in the past? Yes No If yes, when_____

Name_____ For What Problem_____

_____

_____

If you are female, is there a chance that you may be pregnant? Yes No

Fees are payable at the time x-rays, examinations and treatments are received, unless other arrangements are made in advance. X-rays remain property of this clinic.

Patient's Signature_____ Date_____

Parent/Guardian Signature _____Date_____