APPLICATION FOR TREATMENT

Name_____Today's Date_____Age_____

Date of Birth_____/_____/_____Social Security Number_____/_____/_____

Permanent Address_____Apt.#_____
City_____State_____Zip_____

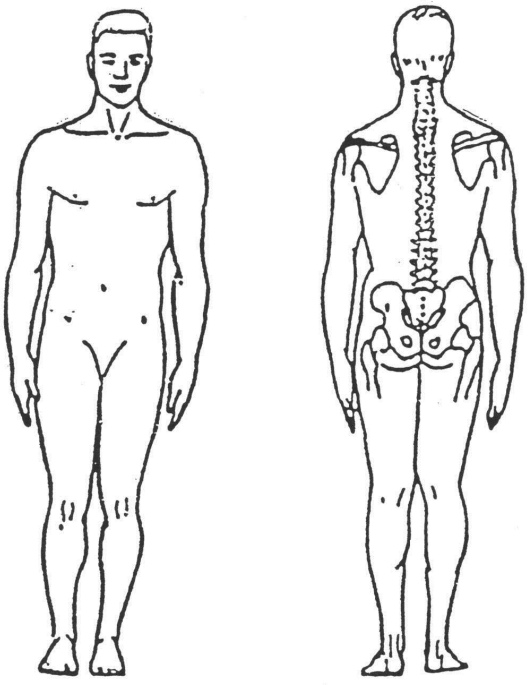
Home Phone #_____Work Phone #_____ Cell #_____
Cell Carrier_____
Local Address_____Apt.#_____
City_____State_____Zip_____
E-mail Address_____Family M.D. Name_____

Insurance Company's name_____
Check if you are: { } Married { }Single { }Widowed { }Divorced (}Separated
Name of Husband or Wife_____ Ages of Children_____
Your Occupation_____Where are you Employed_____

Emergency contact name_____Phone# _____

How will payment be made:{ } Cash { }Check { } Charge { } Automobile Insurance
{ } Health Insurance { } Workers Compensation

Please mark the exact location of your problems



Please list below all health problems you are **currently** having.

_____
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_____

(PLEASE COMPLETE REVERSE SIDE)

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

_____

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

_____

Have you ever had this problem(s) before Yes / No If yes, please explain:

_____

_____

Have you ever received any treatment for this condition(s)? Yes / No If yes, where and when, and what were your results?

_____

_____

Has this problem(s) been getting better, worse or staying the same?

_____

Is there anything you do that makes your condition(s) worse?

_____

How has this condition affected your life? Please explain:

A. Home Life _____

_____

B. Occupational Life _____

_____

C. Recreational Life _____

_____

D. Rest and Sleep Life _____

_____

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(S)?

_____

_____

_____

What surgeries have been done? _____

Please list all medication(s) you are currently using: _____

_____

_____

Any chiropractor consulted in the past? _____ Name: _____

Dates Consulted_____ For what problem?_____

Fees are payable at the time X-rays, examinations, and treatments are received. X-rays remain property of this office.

_____

Patient Signature