

INFORMATION/APPLICATION FOR CARE

The following information is needed in order to better serve you. Please complete all questions. If you need help please ask the receptionist. (PLEASE PRINT.)

Today's Date _____

Name _____
Home Phone _____ Work Phone _____ Cell Phone _____
E-Mail Address _____
Address _____
City _____ State _____ Zip _____
Age _____ Birth date _____ Marital Status: S M W D
Number of Children _____ Ages _____

Employment Status: Full time _____ Part time _____ Unemployed _____ Retired _____ Student _____
Your Employer _____ Occupation _____ Years On Job _____
Employer Address _____
City _____ State _____ Zip _____

Insurance Company _____
Policy ID _____
Your Social Security # _____
Do you have Medicare? Yes _____ No _____

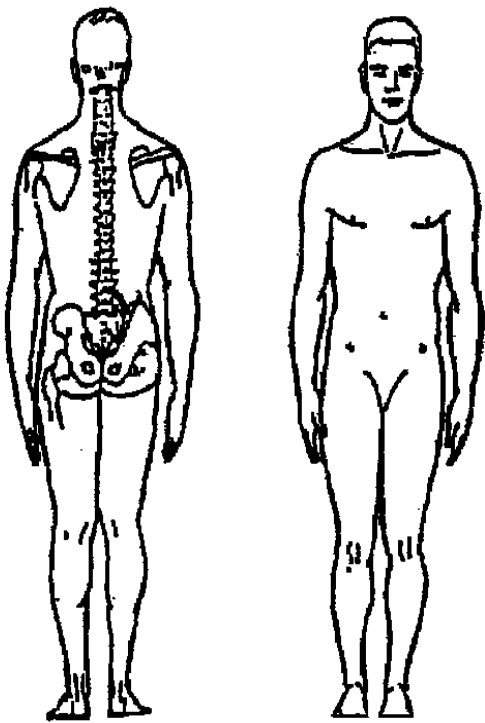
Name of Spouse or Parent _____ Phone _____
Their Birth date _____
Spouse Employed By _____ Occupation _____ Years On Job _____
Employer Address _____
City _____ State _____ Zip _____ Office Phone # _____

Emergency Contact: (A Relative or friend not living in your household)
Name _____ Phone _____

Referred to our office by: _____

How payment will be made:
Cash _____ Check _____ Credit Card _____ Worker's Comp _____ Auto Insurance Policy _____

Is your condition due to an accident? Yes _____ No _____ Date of Accident? _____
Type of accident? Auto _____ Work/On Job _____ At Home _____
Other _____
Have you ever been in an auto accident? Y/N
Past Year _____ Past 5 Years _____ Over 5 Years _____ Never _____



COMPLETE THESE DIAGRAMS

If you are in pain, please mark the exact location of your pain on the diagram. 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, consistent, off & on, when standing, when sitting, etc.....

MAJOR COMPLAINTS

(Please list any condition you are being treated for or are experiencing.)

Notice to our patients:

If for any reason this request cannot be met, arrangements should be made in advance BEFORE seeing the doctor.

We are not a provider for any insurance.

However, as a courtesy to our patients, we will file your claims ON YOUR BEHALF, and your insurance company will reimburse YOU for any treatment which they cover.

I (we) agree to pay for services rendered to the above mentioned patient as the charge is incurred. I understand and agree that health & accident insurance policies are an arrangement between an insurance carrier and myself and that I am personally responsible for payment of any and all services covered or not covered. I also understand that if I suspend or terminate my care and treatment, any fee for professional services rendered me will be immediately due and payable.

Patient's Signature _____ Date _____
Or Guardian Signature _____ Date _____

Confidential Patient Case History

Dear Patient: Please complete this questionnaire. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. THANK YOU.

Name _____ Date _____

Please check the appropriate box for any of the following symptoms which you now have or have had previously. We want all the facts about your health before we accept your case.

THIS IS A CONFIDENTIAL HEALTH REPORT.

O – OCCASIONAL

F – FREQUENT

C – CONSTANT

- Sciatica
- Spinal Curvature
- Swollen joints

O F C

GASTRO-INTESTINAL

- Belching or gas
- Colitis
- Colon trouble
- Constipation
- Diarrhea
- Difficult digestion
- Distension of abdomen
- Excessive hunger
- Gall bladder trouble
- Hemorrhoids
- Intestinal worms
- Jaundice
- Liver trouble
- Nausea
- Pain over stomach
- Poor appetite
- Vomiting
- Vomiting of blood

O F C

GENERAL

- Allergy
- Chills
- Convulsions
- Dizziness
- Fainting
- Fatigue
- Fever
- Headache
- Loss of sleep
- Loss of weight
- Nervousness/depression
- Neuralgia
- Numbness
- Sweats
- Tremors

MUSCLE & JOINT

- Arthritis
- Bursitis
- Foot trouble
- Hernia
- Low back pain
- Lumbago
- Neck pain or stiffness
- Pain between shoulders

Pain or numbness in:

- Shoulders
- Arms
- Elbows
- Hands
- Hips
- Legs
- Knees
- Feet
- Painful tail bone
- Poor posture

EYES, EARS, NOSE & THROAT

- Asthma
- Colds
- Crossed eyes
- Deafness
- Dental Decay
- Earache
- Ear discharge
- Ear noises
- Enlarged glands
- Enlarged thyroid
- Eye pain
- Failing vision
- Far sightedness
- Gum trouble
- Hay fever
- Hoarseness
- Nasal obstruction
- Near sightedness
- Nosebleeds

- Sinus infection
- Sore throat
- Tonsillitis

O F C

CARDIO-VASCULAR

- Hardening of arteries
- High blood pressure
- Low blood pressure
- Pain over heart
- Poor circulation
- Rapid heart beat
- Slow heart beat
- Swelling of ankles

RESPIRATORY

- Chest pain
- Chronic cough
- Difficult breathing
- Spitting up blood
- Spitting up phlegm
- Wheezing

SKIN

- Boils
- Bruise easily
- Dryness
- Hives or allergy
- Itching
- Skin eruptions (rash)
- Varicose veins

GENTO-URINARY

- Bed-wetting
- Blood in urine
- Frequent urination
- Inability to control kidneys
- Kidney infection or stones
- Painful urination
- Prostate trouble
- Pus in urine

FOR WOMEN ONLY

- Congested breasts
- Cramps or backache
- Excessive menstrual flow
- Hot flashes
- Irregular cycle
- Menopausal symptoms
- Painful menstruation
- Vaginal discharge
- Yes No Are you pregnant?

CHECK THE FOLLOWING CONDITIONS YOU HAVE HAD:

- | | | | | |
|---|---|--|---|---|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Cold sores | <input type="checkbox"/> Goiter | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Scarlet fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Gout | <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Mumps | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Eczema | <input type="checkbox"/> Influenza | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Typhoid fever |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Lumbago | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Malaria | <input type="checkbox"/> Polio | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Chorea | <input type="checkbox"/> Fever blisters | <input type="checkbox"/> Measles | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Whooping cough |

PLEASE PRINT

What's your major complaint? _____

List surgical operation and years: _____

Drugs you now take: Nerve pills Pain killers Muscle relaxers

"Pep" pills Tranquilizers Birth control pills

Others: _____

Age of mattress: _____ Comfortable Uncomfortable Do you use a bed board? _____

Are you wearing: Heal lifts Sole lifts Inner soles Arch supports

Have you been in an auto accident: Past year Past five years Over five years Never

Describe: _____

Have you ever had any mental or emotional disorders? Yes No When? _____

Have others in your family had such disorders? Yes No When? _____

HAVE YOU EVER:

Yes No

DESCRIBE BRIEFLY

- Been knocked unconscious? _____
- Used a cane, crutch, or other support? _____
- Been treated for a spine or nerve disorder? _____
- Had a fractured bone? _____
- Been hospitalized for anything other than surgery? _____

DO YOU:

- Now take vitamins or minerals? _____
- Think you may need vitamins or minerals? _____
- Have an allergy to any drug? _____

DATE OF LAST:

Less than 6 months

6-18 months

Over 18 months

Never

- Spinal examination
- Physical examination
- Blood test
- Chest X- ray
- Spinal X-ray
- Dental X-ray
- Urine test

HABITS

Heavy

Moderate

Light

None

- Alcohol
- Coffee
- Tobacco
- Drugs
- Exercise
- Sleep
- Appetite

