APPLICATION FOR TREATMENT

Date: ______________________

Name: ______________________ Date of Birth ______________________

Address: ______________________ City ______________ State ________ Zip Code ________

Home Phone Number: ______________________ Cell phone: ______________________

Where are you employed? ______________________ Work Phone: ______________________

Employer's Address ______________________ City/State ______________________ Zip Code ________

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

Where is your spouse employed? ______________________

Who is responsible for your bill? ____ Self ____ Spouse ____ Employer ____ Insurance ____ Other

How will PAYMENT be made? ____ CASH ____CHECK (local checks only) ____ Credit Card

Name of HEALTH insurance company ______________ ID #: ______________ Phone ______________

Name of Automobile Ins. Company ______________ CL#: ______________ Phone______________

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, when sitting, etc., etc.

COMPLETE THESE DIAGRAMS

MAJOR COMPLAINT
(Please describe only your major problem)

____

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

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

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? ______________________

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

(PLEASE COMPLETE REVERSE SIDE)

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Does it interfere with your ____ Work ____ Sleep ____ Daily Routine ____ Recreation

Activities or movements that are painful to perform ____ Sitting ____ Standing ____Walking ____ Bending ____ Lying Down

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 ____________________

What surgery has been done? ____________________

Are you pregnant? ____ Yes ____ No

MEDICATIONS YOU NOW TAKE ____________________

Are you allergic to any medications? (Please list) ____________________

Do you have a PACEMAKER? ____ Yes ____ No

Do you have a DEFIBRILLATOR? ____ 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 the property of this clinic. In the event of default by the patient, he/she agrees to pay the amount actually incurred by the doctor to secure collection hereunder as court cost, attorney's fees set by a court, lawful fee for filing, recording or releasing in any public office any document securing an account.

Patient's Signature: ____________________ Social Security No ____________________ Date ____________

IF YOURS IS AN ACCIDENTAL INJURY, PLEASE COMPLETE THE FOLLOWING QUESTIONS

Date of accident: ____________ Hour: ____AM ____PM Location: ____________________

How did accident occur? ☐ Auto Collision ☐ On-the-Job Injury ☐ Other ____________

If not an auto collision, please describe the circumstances: ____________________

Did you report the injury to your foreman or employer? ☐ YES ☐ NO

Did he (they) recommend care at our office? ☐ YES ☐ NO

If auto accident, were you ☐ Driver? ☐ Passenger? ☐ Pedestrian?

If auto collision, were you struck from ☐ Behind? ☐ Right Side? ☐ Left Side? ☐ Front? ☐ Auto was parked

Did your car strike the other(s) involved? ☐ YES ☐ NO; Or did the other car strike yours? ☐ YES ☐ NO ☐ Undetermined

As a result of the accident, were traffic citations issued to you? ☐ YES ☐ NO; To the driver of the other car? ☐ YES ☐ NO

To the driver of your car? ☐ YES ☐ NO; List the extent of the injuries as you know them: ____________________

Did you require post-accident hospitalization? ☐ YES ☐ NO

CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:

☐ Headache	☐ Irritability	☐ Numbness in Toes	☐ Face Flushed	☐ Feet Cold
☐ Neck Pain	☐ Chest Pain	☐ Shortness of Breath	☐ Buzzing in Ears	☐ Hands Cold
☐ Neck Stiff	☐ Dizziness	☐ Fatigue	☐ Loss of Balance	☐ Stomach Upset
☐ Sleeping Problems	☐ Head seems too heavy	☐ Depression	☐ Fainting Spells	☐ Constipation
☐ Back Pain	☐ Pins & Needles in Arms	☐ Light bothers Eyes	☐ Loss of Smell	☐ Cold Sweats
☐ Nervousness	☐ Pins & Needles in Legs	☐ Loss of Memory	☐ Loss of Taste	☐ Fever
☐ Tension	☐ Numbness in Fingers	☐ Ears Ring	☐ Diarrhea	☐ ________

Symptoms other than above: ____________________

Have you lost any days of work? ☐ YES ☐ NO Dates: ____________________

Name of Your Insurance Company involved: ____________________

Name of Insurance Company of person responsible for injuries: ____________________

Have you been contacted by an Insurance Adjuster or Company Representative regarding this claim? ☐ YES ☐ NO

Do you have an attorney who has advised you in this case? ☐ YES ☐ NO Name: ____________________

Address of attorney: ____________________ Phone No: ____________________

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