APPLICATION FOR TREATMENT

NAME:_____SOCIAL SECURITY#_____DATE:_____

Address:_____City:_____ State:_____ Zip:_____

Date of Birth:_____Age:_____Cell#_____

Work#_____
Home#_____

E-mail Address:_____

Marital Status: M S W D Spouse's Name_____Ages of Children_____

Employer:_____Spouse's Employer:_____

How were you referred to our office:_____

Primary Insurance Company:_____ Secondary Insurance Company:_____

Describe your Major Complaint:_____

How did it start or what caused it?
_____

Have you ever had this similar problem before?_____If yes, When?
_____

Have you received any other treatment for this condition?_____ If yes, where, when, and what were the results?

_____

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

Is there anything that you do that makes the condition worse?
_____

Is there anything that you do that makes the condition better?
_____

How frequent is the pain?
_____

How has the condition affected your daily activities?
Home:_____Work:_____Recreation:_____Sleep:_____

Describe the pain (sharp, dull, ache, burning, stabbing)_____

Have you felt any numbness or tingling in your arms, hands, legs or feet?

_____

List any and all automobile accidents you have been involved in (even minor fender-benders), and if you received any injuries:

_____

List any falls you have had, the date, and if you received any injuries:_____

List any broken bones you have sustained and their dates:_____

List any and all surgeries and dates you have undergone (including tonsils, appendix, gallbladder, etc.)_____

List any major illnessess or diseases you have or had in the past:_____

List all the medications you are currently taking:_____

List any chiropractors you have seen in the past:_____

When was your last physical exam:_____