APPLICATION FOR TREATMENT

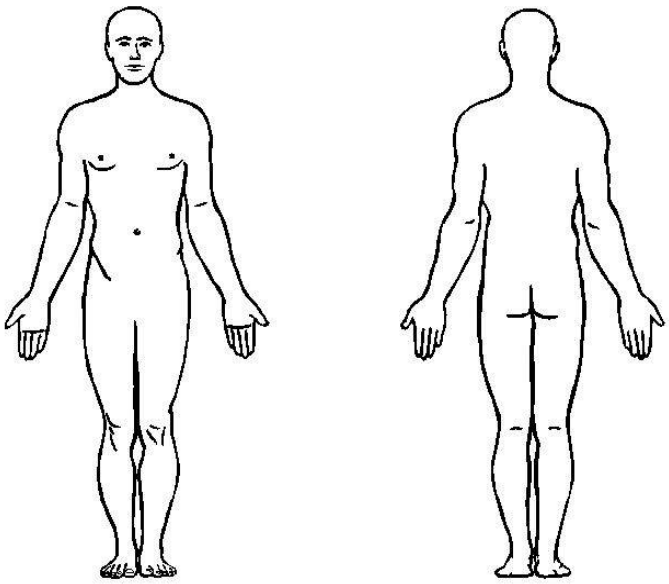
DATE: _____

Name: _____ Cell#: _____
Address: _____ City:_____ Zip Code:_____
Age: _____ DOB: ___/___/___ Marital Status: M S W D SS#: ____-____-____ D. Lic#:_____
Email: _____
Employer: _____ Occupation: _____Phone#: _____
Address: _____ Name of Spouse: _____
Phone#: _____ His/her employer: _____ Phone#:_____

Emergency contact (Different Address): _____ Relationship: _____
Phone: _____ Address: _____ City: _____ Zip Code: _____

Who is financially responsible for your bill? _____
I will be paying today by? □ Cash □ Check □ Credit Card □ Other: _____

Name of insurance company: _____ Phone#: _____
Address: _____ Policy#: _____
How were you referred? _____



□ Headache □ Neck Pain □Stiff Neck □Sleeping Problems
□Back Pain □Nervousness □Tension □Numbness in Toes
□Shortness of Breath □Fatigue □Depression □Loss of memory
□Eyes sensitive to light □Ringing in ears □Flushed face
□Buzzing in ears □Loss of balance □Fainting spells □Diarrhea
□Loss of smell □Loss of taste □Irritability □Chest pain
□Dizziness □Head seems heavy □Pins & Needles in arms
□Pins & Needles in legs □Numbness in fingers □Cold feet
□Cold hands □Upset Stomach □Constipation □Cold Sweats
□Fever □Other: _____

Comments:

Have you suffered from: □Heart Problems □Diabetes □Sinus Trouble □Anemia □Rheumatic Fever □Cancer □Arthritis □Tuberculosis □Stomach Ulcers □Liver Trouble □Hemorrhoids □Asthma

How did this condition develop? (What caused it? How did it start? When 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 received any treatment for this condition? If yes, where and what were your results:

_____

_____

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

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

How has this condition affected your life?

A. Home Life: _____

B. Occupation: _____

C. Recreation: _____

D. Rest and Sleep: _____

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? _____

_____

Any previous surgeries? _____

Drugs you now take: □Nerve Pills □ Pain Killers □Muscle Relaxers □"Pep" Pills □Tranquilizers □Insulin □Birth control pills □ Other: _____

Any Chiropractor consulted in the past? Name: _____

Date consulted: _____ For what problem? _____

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

Patient's Signature: _____ Date: _____

IF THE REASON OF YOUR VISIT IS AN ACCIDENTAL INJURY, PLEASE COMPLETE THE FOLLOWING QUESTIONS.

Date of accident: _____ Hour: _____ AM_____PM Location: _____

How did this accident occur? □Auto collision □ On-the-job Accident □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 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
Have you lost any days of work? □Yes □No Dates: _____
Your Auto Insurance Company: _____ Phone#: _____
Address: _____
Insurance Company of the person responsible for injuries: _____ Phone#: _____
Address: _____
Have you been contacted by an Insurance Adjuster or Company Representative regarding this claim? □Yes □No
Do you have am attorney who has advised you in this case? □Yes □No Name: _____
Address of attorney_____ Phone#: _____