

# APPLICATION FOR TREATMENT

(Confidential)

Case # \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Cell phone \_\_\_\_\_ Email address \_\_\_\_\_  
Phone (Home) \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: M F Marital Status: S M D W # Children \_\_\_\_  
Referred by \_\_\_\_\_ Previous Chiropractic Care \_\_ Yes \_\_ No When \_\_\_\_\_  
Previous Chiropractic Doctor's Name \_\_\_\_\_ Results \_\_\_\_\_  
Family Doctor's Name (i.e. M.D.) \_\_\_\_\_  
Your Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ State & Driver's License # \_\_\_\_\_  
Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Phone(Work) \_\_\_\_\_ Ext. \_\_\_\_\_  
Primary Insurance Company \_\_\_\_\_ Policy # \_\_\_\_\_  
Spouse/Secondary Insurance Co. \_\_\_\_\_ Policy # \_\_\_\_\_  
Spouse (Parent if minor) Name \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Telephone(Work) \_\_\_\_\_  
**Areas of Complaint/Pain/Problem(s)** \_\_\_\_\_

Do you suffer from any condition other than that for which you are now consulting us? Yes No What? \_\_\_\_\_

## **Operations and Procedures (Please check and approximate date)**

DATE		DATE		DATE	
_____	Vaccinations	_____	Tubes in Ears	_____	Sinus
_____	Tonsillectomy	_____	Appendectomy	_____	Hernia
_____	Gall Bladder	_____	Female Organs	_____	Thyroid
_____	Back Operation	_____	Rectal Surgery	_____	Stomach
_____	Other _____	_____	Other _____	_____	Other _____

\_\_\_\_\_ I have never had any operations/surgeries.

## **HAVE YOU HAD ANY OF THE FOLLOWING DISEASES? (Check all you've had)**

___ 541 Appendicitis	___ 280 Anemia	___ 429.9 Heart Disease	___ 716 Arthritis
___ 480 Pneumonia	___ 055 Measles	___ 240 Goiter	___ 345 Epilepsy
___ 390 Rheumatic Fever	___ 072 Mumps	___ 487 Influenza	___ 319 Mental Disorder
___ 045 Polio	___ 052 Chicken Pox	___ 511 Pleurisy	___ 724.2 Lumbago
___ 011 Tuberculosis	___ 250 Diabetes	___ 305.0 Alcoholism	___ 690 Eczema
___ 033 Whooping Cough	___ 239 Cancer	___ 099 Venereal Infection	___ 044 HIV Positive

List any/all accidents or falls and dates: \_\_\_\_\_ Car \_\_\_\_\_ Recreational Vehicle \_\_\_\_\_  
\_\_\_\_\_ Sports \_\_\_\_\_ School \_\_\_\_\_ Accident \_\_\_\_\_ Other \_\_\_\_\_

List any broken bones (fractures) or dislocations: \_\_\_\_\_ **I have never been injured.**

Ever on crutches? Yes No When & Why? \_\_\_\_\_

Have you ever had any spinal taps or spinal injections? Yes No When \_\_\_\_\_

Were you ever knocked unconscious? Yes No Have you ever had a lapse of memory? Yes No

Have you ever had Spinal X-rays taken? Yes No Date? \_\_\_\_\_ By Whom? \_\_\_\_\_

For what ailments were these X-rays made? \_\_\_\_\_

Are you presently taking any medication - prescription or over-the-counter? Yes No What drugs? \_\_\_\_\_

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any reasonable necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to examine and treat my condition as he deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed the amount paid to Doctor for X-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient agrees that he/she is responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

The entire balance is due thirty (30) days from the date of this statement. A finance charge of 1.5% per month (18% per year) will be charged and added to any unpaid balance not paid within ninety days.

Patient's/Guardian's Signature X \_\_\_\_\_ Date \_\_\_\_\_

Please mark a **zero, one, or two** in the space in front of *EVERY* item below. **0=Never, 1=Previously, 2=Presently (or very recent).**

**GENERAL SYMPTOMS**

- 995.3 Allergy (What) \_\_\_\_\_
- 780.9 Chills
- 780.3 Convulsions
- 780.4 Dizziness
- 780.2 Fainting
- 780.7 Fatigue
- 780.6 Fever
- 784.0 Headache
- 780.52 Loss of Sleep
- 783 Loss of Weight
- 799.2 Nervousness
- 729.2 Neuralgia-nerve pain
- 780.8 Night Sweats
- 782 Numbness, Tingling or Pain in arms/legs/hands (circle)

**GASTRO-INTESTINAL**

- 787.3 Belching or Gas
- 789.0 Colon Trouble
- 564.0 Constipation
- 558.9 Diarrhea
- 783.6 Excessive Hunger
- 575.9 Gall Bladder Trouble
- 455.6 Hemorrhoids (Piles)
- 782.4 Jaundice
- 794.8 Liver Trouble
- 787.0 Nausea
- 536.8 Pain over Stomach
- 783.0 Poor Appetite
- 536.8 Poor Digestion
- 787.0 Vomiting
- 578.0 Vomiting Blood

**EYE/EAR/NOSE/THROAT**

- 493.9 Asthma
- 378.9 Crossed Eyes
- 389.9 Deafness
- 388.70 Earache
- 388.60 Ear Discharges
- 388.30 Ear Noises
- 240.9 Enlarged Thyroid
- 460 Frequent Colds
- 477.9 Hay Fever
- 784.49 Hoarseness
- 478.1 Nasal Obstruction
- 784.7 Nose Bleeds
- 379.91 Pain in Eyes
- 368.9 Poor Vision
- 473.9 Sinusitis
- 462 Sore Throats
- 463 Tonsillitis

**RESPIRATORY**

- 786.50 Chest Pain
- 786.2 Chronic Cough
- 786.09 Difficulty Breathing
- 786.3 Spitting Blood
- 786.4 Spitting Phlegm
- 786.09 Wheezing
- 491 Bronchitis

**GENITO-URINARY**

- 788.3 Bed Wetting
- 599.7 Blood in Urine
- 788.4 Frequent Urination
- 788.3 Inability to Control Urine
- 590.9 Kidney Infection
- 788.1 Painful Urination
- 601.9 Prostrate Trouble

**MUSCLES & JOINTS**

- 724.5 Backache
- 719.7 Foot Trouble
- 550.0 Hernia
- 719.1 Pain Between Shoulders
- 724.6 Painful Tail Bone
- 723.9 Stiff Neck
- 781.9 Spinal Curvature
- 719.0 Swollen Joints
- 781.0 Tremors

**CARDIO-VASCULAR**

- 401.9 High Blood Pressure
- 458.9 Low Blood Pressure
- 786.51 Pain over Heart
- 785.9 Poor Circulation
- 438 Previous Heart Trouble
- 785.0 Rapid Heart
- 427.89 Slow Heart
- 436 Strokes
- 782.3 Swelling Ankles
- 454 Varicose Veins

**SKIN OR ALLERGIES**

- 690 Boils
- 924.9 Bruising Easily
- 701.1 Dryness
- 691.8 Eczema
- 708.9 Hives or Allergy
- 698.9 Itching
- 782.0 Sensitive Skin
- 368.9 Skin Eruptions

**FOR WOMEN ONLY**

- 625.3 Cramps/Backaches every month  alternates
- 626.2 Excessive Flow
- 627.2 Hot Flashes
- 626.4 Irregular Cycle
- 634.9 Miscarriage
- 625.3 Painful Periods
- 623.5 Vaginal Discharge
- No  Pregnant at this Time
- /  Last Pap

**SHOW US WHERE IT HURTS**

Please mark areas of symptoms as shown in example using a scale of 0=no symptom 10=severe.

Are your present problems due to an injury?

- Yes  No
- On the Job
- Auto Accident
- Personal Injury (liability)
- Other \_\_\_\_\_

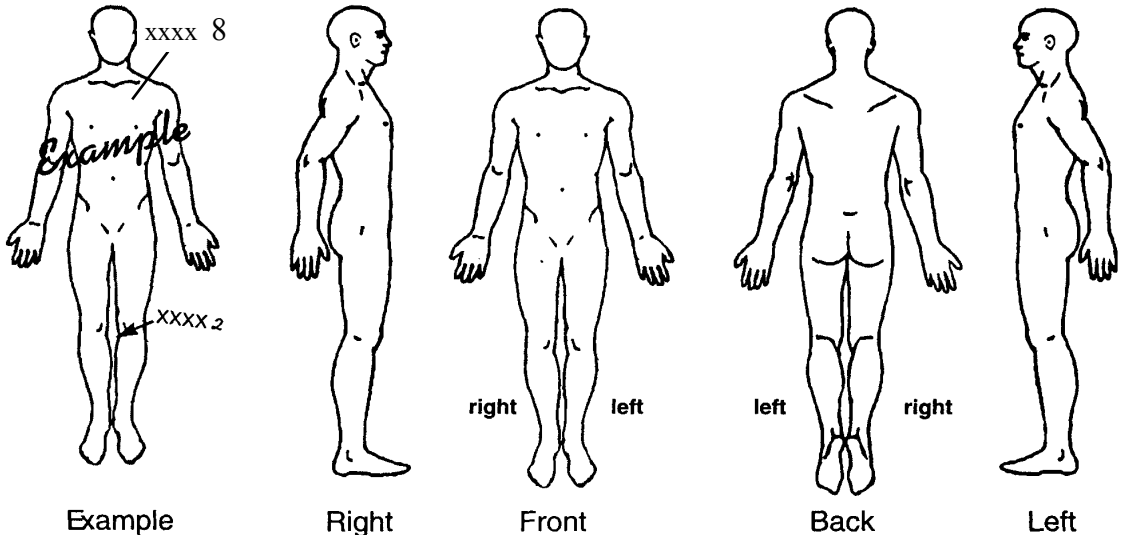
Has the accident been reported  No  Yes

- To Employer
- Auto Carrier
- Other \_\_\_\_\_

Are you now or have you ever been disabled? (Service or Work)? Yes No When? \_\_\_\_\_

Have you retained an attorney?  No  Yes Name & Address \_\_\_\_\_

- Other  / / / / /
- Numbness  - - - -
- Pins & Needles  O O O O
- Burning  ^ ^ ^ ^ ^
- Aching  X X X X X
- Stabbing  • • • • •



**HABITS**

- Smoking Packs/Day \_\_\_\_\_
- Drinking Alcohol \_\_\_\_\_
- Coffee Cups/Day \_\_\_\_\_

**EXERCISE**

- None
- Moderate
- Daily
- \_\_\_\_\_ Type

**FAMILY HISTORY (check)**

	Diabetes	Heart	Back	Cancer	Living? - Age
Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brother, # of _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sister, # of _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>