FIRST *family chiropractic* WELLNESS

APPLICATION *for* TREATMENT

Date ______________________

Name______________________________________ Age__________ Birth date ________________

Address ____________________________ City ______________ State _____ ZIP Code __________

Home Phone ____________________ Work Phone ______________ Cell Phone ________________

E-Mail Address ______________________________ Referred by ___________________________

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

Employer ____ Occupation __________________

Please describe the principal health problems that brought you to our office: ________________________

____

____

How and when did symptoms first occur? ____

List any other doctors seen for these problems: ____

List diagnosis(es) and type of treatment(s): ____

____

____

Does this interfere with your normal living and work? Yes ☐ No ☐ In what way?________________

____

Have you lost any days of work? Yes ☐ No ☐ Dates ___________________________________

Have you had similar symptoms or injuries before? Yes ☐ No ☐ If yes, explain ______________

____

List the names of any relatives that have or have had a similar problem _______________________

____

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

How payment will be made: Cash ☐ Check ☐ Credit Card ☐ Worker's Compensation ☐

Type of Insurance: Health Insurance ☐ Automobile Ins. Policy ☐

If work related, name of company and address ____

____

Emergency Contact (name and phone number): ____

PAST HISTORY

Has a physician treated you for any health condition in the last year? Yes ☐ No ☐

If yes, explain: ____

____

Have you or any relative received Chiropractic treatment previously? Yes ☐ No ☐

If yes, explain ______________________________

____

List the approximate dates of any operations, unusual diseases, serious illnesses or accidents you have had (include any broken bones): ______________________________

____

List all drugs or medication that you have used recently (i.e., aspirin, sleeping pills, birth control pills, etc.):

____

____

FAMILY HISTORY

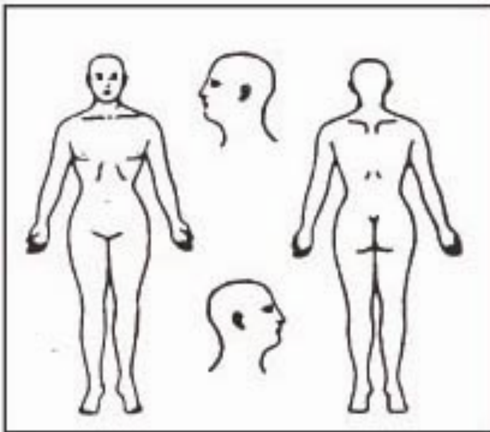
Name of wife or husband ______________________________ Ages of children ______________

Spouse's Employer ______________________________ Business Phone ______________

You're Nearest Relative ______________________________

Relative's Address ______________________________

Please mark your areas of pain on the figure below:



List the conditions that you are most interested in getting corrected. List in order of importance:

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________

What functions are you unable to perform or induce pain upon performance? List in order of severity. (Example: sitting, walking, bending, lying down, etc.)

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________

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. I HEREBY GIVE PERMISSION FOR TREATMENT.

Signature of Patient ______________________________ Social Security Number ______________