PATIENT APPLICATION FOR TREATMENT

Name:(L)_____(F)_____(MI)____Date:_____
Address:_____Home Phone:_____ Cell Phone:_____
City:_____State:___Zip:_____ Email:_____
Birth Date:___/___/___Age:___Gender: M__F__Marital Status: M W D S SS#_____
Spouse's Name:_____Emergency Contact:_____Phone #_____
Children's Names & Ages:_____
Have they or any of your family members received chiropractic care? ___Yes ___No
Have you ever had chiropractic care? ___Yes ___No How long has it been?_____
Favorite Hobbies/Interests_____
Employed By:_____Occupation:_____
Address:_____Work Phone:_____
Who is financially responsible for this bill?_____Method of Payment: ___cash___check___cc
Who may we thank for referring you?_____
How often do you drink alcoholic beverages?_____
Do you smoke? ___Yes ___No How much?_____
Do you exercise? ___Yes ___No How often?_____Type?_____
Chief Complaints: (1)_____(2)_____(3)_____

DO YOU HAVE ANY ALLERGIES? (SPECIFY): _____

HAVE YOU EVER SUFFERED FROM OR BEEN DIAGNOSED AS HAVING: (CIRCLE YES OR NO FOR EACH)

Y	N	*Broken or Fractured Bones	Y	N	*Osteoarthritis	Y	N	Eating Disorder
Y	N	Circulatory Problems	Y	N	Epilepsy	Y	N	Alcoholism
Y	N	*Rheumatoid Arthritis	Y	N	Pacemaker	Y	N	Drug Addiction
Y	N	Seizures/Convulsions	Y	N	Strokes	Y	N	HIV Positive
Y	N	A Congenital Disease	Y	N	*Cancer	Y	N	Gall Bladder
Y	N	Excessive Bleeding	Y	N	Ulcers	Y	N	*Head Problems
Y	N	High/Low Blood Pressure	Y	N	Ruptures	Y	N	Depression
Y	N	*Diabetes	Y	N	Coughing Blood	Y	N	Tumors

* Explanation: _____

WHEN WAS YOUR LAST PHYSICAL EXAM? _____

WHEN WAS THE LAST TIME YOU WERE INVOLVED IN AN ACCIDENT OF ANY KIND? _____

FOR DOCTOR'S USE ONLY

☐ GENERAL

INJURY TYPE:

☐ NDRA

DRUG ALLERGIES:

☐ SEE MEDS ADDENDUM

MEDICATION LIST

NAMES OF MEDICATION	NAMES OF VITAMINS	NON-Rx STRENGTH	Rx STRENGTH	DATE STARTED	DATE STOPPED	WHO PRESCRIBED DR. / SELF	
						D	S
						D	S
						D	S
						D	S
						D	S