APPLICATION FOR TREATMENT

Please check the type of care desired: □ **Temporary Relief** □ **Lasting Correction** **Date:**___________________

Name:____ **Date of Birth:**_____________________________

Address:_______________________________________ **City**________________ **State**________ **Zip Code**______

Email Address:____

Home Phone:______________________**Work Phone:**______________________ **Cell Phone:**________________

Check if you are: □ **Married** □ **Single** □ **Widowed** □ **Divorced** □ **Separated**

Spouses Name:____ **Ages of Children:**_________________________

Where are you or your spouse employed?____

Your days off:______________________ **Referred to our office by:**______________________________________

Who is responsible for your bill: □ **Self** □ **Spouse** □ **Employer** □ **Insurance** □ **Other**_______________

How Payment will be made: □ **Cash** □ **Check** □ **Credit/Debit Card**

Type of Insurance: □ **Health Ins.** □ **Automobile Ins.** □ **Workmen's Comp**

Please describe your major concern for today's visit:____

____

____

____

How did this condition develop? (What caused it? How did it start?)__________________________________

____

____

When was the very first time you were aware of this problem?____

____

Have you ever had this problem or a similar problem before? If yes, please explain:______________________

____

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

____

____

Has this problem been getting better, worse, or staying the same?_______________________________________

Is there anything that makes your condition worse?____

How has this condition affected your life?

- **Home life:**____
- **Work life:**____
- **Recreational life:**____
- **Rest and Sleep life:**____

Have you ever been in an automobile accident? □ **Past year** □ **Past 5 years** □ **Over 5 years** □ **Never**
ANY ACCIDENTS, FALLS OR INJURIES THAT MIGHT HAVE CAUSED YOUR PROBLEM?_____________________________

____

Date of Injury:_____________________ **ANY MEDICAL DIAGNOSIS OF YOUR COMPLAINT?**___________________

____

What surgery has been done?____

____

(*PLEASE COMPLETE REVERSE SIDE*)

Are you pregnant? □ **Yes** □ **No**

DRUGS YOU NOW TAKE: □ **Nerve Pills** □ **Pain Killers** □ **Muscle Relaxers** □ **"Pep" Pills** □**Tranquilizers** □ **Insulin** □ **Birth Control Pills** □ **Other (Please list)**____

ANY CHIROPRACTOR CONSULTED IN THE PAST? Name:____
Dates Consulted:__________________________ **For what problem?**____

Please check any of these you believe may be causing you any problems:

□ **Shell Fish**
□ **Fruits, Berries, Nuts**
□ **Eggs, Grains**
□ **Animal Dander, Feathers, Fur**
□ **Nightshades (Tomatoes, Potatoes, Peppers)**
□ **Fabrics, Upholstery, Plastics**
□ **Skin issues (Acne, Eczema, Psoriasis, Poison Ivy)**
□ **Pain or Nerve Issues**
□ **Dairy (Milk, Cheese, Yogurt)**
□ **Chemicals, Latex**
□ **Other**____
□ **Coffee, Chocolate, Tea (caffeine)**
□ **Perfumes, Candles, Oils, Shampoo, Makeup**
□ **Nutritional Supplements, Herbal Remedies**
□ **Pollen, Grass, Trees, Mold**
□ **Metals**
□ **Stinging Insects**
□ **Seasonal Allergies**
□ **Chemicals, Latex**
□ **Asthma, Breathing Issues**
□ **Digestive Issues (Bloating, Gas)**

□ **ADD/ADHD**
□ **Angry Outbursts**
□ **Chronic Pain**
□ **Depression**
□ **Excessive Self-Concern**
□ **Insomnia (Trouble Falling/Staying Asleep)**
□ **Migraine / Tension Headaches**
□ **Panic Attacks**
□ **PTSD**
□ **Rumination**
□ **Brain cannot shut off**
□ **Tics (Verbal / Motor)**
□ **Other**____
□ **Agitation**
□ **Anxiety**
□ **Peak Performance**
□ **Emotional Trauma**
□ **Excessive Worry**
□ **Memory Loss**
□ **OCD (Obsessive Compulsive Disorder)**
□ **Passive Aggressive**
□ **Restlessness**
□ **Socially Inappropriate**
□ **Spontaneous episodes of tearfulness**
□ **Traumatic Brain Injury**

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.

Patients Signature____ **Social Security No.**________________________________

Date:______________________________