

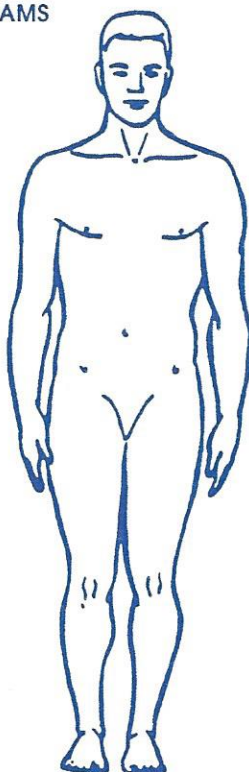
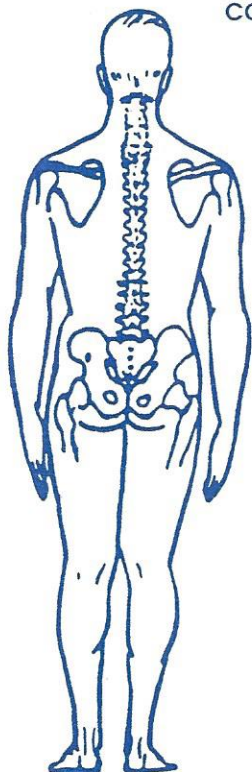
TREATMENT APPLICATION

Please check the type of care desired: Temporary Relief Lasting Correction
 Check here if you want the Doctor to recommend the best type of care for you.

Name: _____ Date: _____
Date of Birth: _____
Address: _____ City _____ State _____ Zip Code _____
Home Phone Number: _____ Phone at Work: _____
Check if you are: Married Single Widowed Divorced Separated
Name of Husband or Wife: _____ Ages of Children: _____
Where are you or husband/wife 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: Type of Insurance
_____ Cash _____ Workers' Comp. _____ Health Insurance
_____ Check _____ Automobile Ins. Policy

Name of Company and Address _____

COMPLETE THESE DIAGRAMS



MAJOR COMPLAINT

(Please describe only your major problem)

If you are in pain, please mark the exact location of your pain on the diagram above. Also describe the type and frequency of your pain, as well as any activity which brings on or aggravates the pain. For example, dull, sharp, constant, off & on, when standing, when sitting, etc., etc.

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 similar problem before? If yes, please explain: _____

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

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

(PLEASE COMPLETE REVERSE SIDE)

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

How has this condition affected your life?

- A. Home life _____
- B. Occupational life _____
- C. Recreational life _____
- D. Rest and Sleep life _____

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 _____

What surgery has been done? _____

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? _____

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.

Patient's Signature: _____ Social Security No. _____ Date _____

IF YOURS IS AN ACCIDENTAL INJURY, PLEASE COMPLETE THE FOLLOWING QUESTIONS

Date of accident: _____ Hour: ____ AM ____ PM Location: _____
How did accident occur? Auto Collision On-the-Job Injury 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 car 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

CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:

- | | | | | |
|--|---|--|--|--|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Irritability | <input type="checkbox"/> Numbness in Toes | <input type="checkbox"/> Face Flushed | <input type="checkbox"/> Feet Cold |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Buzzing in Ears | <input type="checkbox"/> Hands Cold |
| <input type="checkbox"/> Neck Stiff | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Stomach Upset |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Head seems too heavy | <input type="checkbox"/> Depression | <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Pins & Needles in Arms | <input type="checkbox"/> Light bothers Eyes | <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Cold Sweats |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Pins & Needles in Legs | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Loss of Taste | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Numbness in Fingers | <input type="checkbox"/> Ears Ring | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> _____ |

Symptoms other than above: _____

Have you lost any days of work? YES NO Dates: _____

Name of Your Insurance Company involved: _____

Name of Insurance Company of person responsible for injuries: _____

Have you been contacted by an Insurance Adjuster or Company Representative regarding this claim? YES NO

Do you have an attorney who has advised you in this case? YES NO Name: _____

Address of attorney: _____ Phone No.: _____