WALKER CHIROPRACTIC

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APPLICATION FOR TREATMENT

Personal Information

Name: _____ Today's Date: ____/____/____

Address: _____
Street ZIP State

E-mail Address: _____

Birth Date: ____/____/____ Age: _____ Are you Pregnant? Yes ☐ No ☐ _____ # of weeks

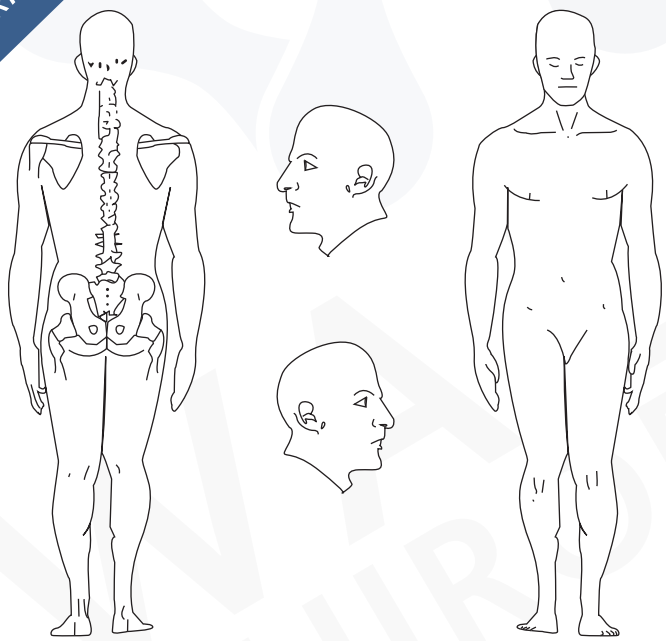
Employer's Name & Address: _____

Occupation: _____ Work Phone #: _____ Cell Phone #: _____ Home Phone #: _____

What type of care do you desire: ☐ Temporary Relief ☐ Lasting Correction ☐ Best Care Possible

Personal Information

Please circle the exact location of any pain you are experiencing. Then describe the type of pain, i.e. dull, sharp, costant, on & off, etc.



In order of importance, list the body parts that are bothering you the most:

1) _____
2) _____
3) _____
4) _____
5) _____

In order of severity, list those body functions that you are unable to perform, or that produce pain upon performance, i.e. walking, sitting, bending, etc.

1) _____
2) _____
3) _____
4) _____
5) _____

When was the first time you noticed this problem:

_____
_____

Describe any accidents, falls, injuries, sudden movements, etc. that may have caused your problem:

_____
_____

Have you had any similar health problems or injuries before? Yes ☐ No ☐ If yes, please explain:

_____
_____

Name all the doctors you have seen for this problem, and what diagnosis and type of treatment you received (please include where and when you received treatment, and the results):

_____
_____
_____
_____
_____

(Please complete reverse side)

Has your health problem been: ☐ Improving ☐ Worsening ☐ Staying the Same

Please describe anything you do that improves your condition, or worsens it:

_____

_____

Please check off and describe how this problem interferes with your work and/or personal life:

- ☐ Home Activities Effected: _____
- ☐ Work Activities Effected: _____
- ☐ Have you missed any work days? Yes ☐ No ☐ If yes, dates missed: _____
- ☐ Recreational Activities Effected: _____
- ☐ Rest or Sleep Effected: _____

Previous Health History

During the last year, has a doctor treated you for any health problem? Yes ☐ No ☐

If yes, explain: _____

_____

_____

Have you ever received Chiropractic care? Yes ☐ No ☐ If yes, please list the doctor's name, location of office and for what problems: _____

_____

_____

Please check off the drugs you are now taking: ☐ Pain Killers ☐ Muscle Relaxers ☐ Anti-inflammatory ☐ Blood Pressure Medication ☐ Insulin ☐ Birth Control Pills ☐ Tranquilizers ☐ Diet Pills ☐ Nerve Medication ☐ Sleeping Pills ☐ Anti-depressants ☐ Other (please list) : _____

_____

List the approximate dates of any accidents, operations or serious injuries (including broken bones) you have had: _____

_____

_____

_____

Do you currently have any open cases with an attorney, insurance company, or worker's compensation? Yes ☐ No ☐

If you have been in an automobile accident, when? ☐ This Year ☐ Last Year ☐ Past 5 Years ☐ Over 5 Years

Family Health History

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Names & Ages of Children: _____

Name of spouse: _____

Spouse's Employer: _____ Business Phone: _____

Family Health History

Who is responsible for your bill? ☐ I am ☐ Spouse ☐ My Employer ☐ Insurance ☐ Other: _____

Type of Insurance: ☐ Worker's Comp. ☐ Health ☐ Automobile

Insurance Company's Name & Address: _____

_____

If you are responsible for your health care fees, payment will be made by: ☐ Cash ☐ Check ☐ Credit Card

Your fees are due and payable at the time examinations, X-rays, and treatments are received, unless other arrangements have been made in advance. X-rays remain property of this clinic and can be formatted to a disc for a fee of $25.

I, the undersigned, hereby give permission for treatment.

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