

PATIENT APPLICATION FOR TREATMENT

Today's Date: _____ MR# _____

Name: _____ How would you like to be addressed? _____

Date of birth: _____ Age: _____ Gender: _____

Your Address: _____ City: _____

State: _____ Zip: _____ Home Phone: _____ E-mail: _____

Your Occupation: _____ Mobile Phone: _____

Employer: _____ Work Phone: _____

Supervisors Name: _____ Social Security Number: _____

Address / Location: _____ City: _____ State: _____ Zip: _____

Spouses Name: _____ Occupation: _____

Employer: _____ Work Phone: _____

How many children do you have? _____ What are their ages? _____

Have they or any other members of your family ever received chiropractic care? Yes No

Have you ever had chiropractic care? Yes No How long has it been? _____

Purpose or reason for this appointment: _____

How often do you drink alcoholic beverages? _____

Do you Smoke? Yes No How much? _____

Do you exercise? Yes No How often? _____ Type? _____

Have you ever suffered from or been diagnosed as having: (circle Yes or No for each)

- | | | |
|-------------------------------|---------------------|---------------------|
| Y N *Broken / 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 Pace Maker | 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 |

When was your last physical exam? _____

When was the last time you were involved in an accident of any kind?

_____ Days _____ Weeks _____ Months _____ Years (Approximately)

Please list and identify with a (✓) all vitamins (V), prescriptions (Rx) and non-prescription (Non-Rx) medications you have taken over the past year and/or are currently taking: (circle who prescribed, Doctor or Self.)

MEDICATION LIST

Names of medication or vitamins	V	Non-Rx	Rx Strength	Date Started	Date Stopped	Who?	
						D	S
				/ /	/ /	D	S
				/ /	/ /	D	S
				/ /	/ /	D	S
				/ /	/ /	D	S
				/ /	/ /	D	S
				/ /	/ /	D	S
				/ /	/ /	D	S

FOR DOCTORS USE ONLY

General

Injury Type: _____

NDRA

Drug Allergies: _____

See Meds Addendum