NEW PATIENT APPLICATION

Dilliard CHIROPRACTIC P.C.

Saturday, November 10, 2018

File #

Name
sdfg asdf

Date of Birth

Sex

Weight

Cell Phone #
(408) 6607878

Email
info@demandboost.website

Today's Date

Address
123451634, 1234
1234, 1234, 1234

Age:

Height:

Occupation

Employer

I prefer to receive appointment reminders by :

Text Message

Social Security #

Driver's License #

Spouse's Name

Spouse's Employer

Number of Children #

Ages #

Name of Primary Care Doctor

Phone Number

Address

Emergency Contact:

Emergency Phone Number

Relationship

HISTORY of CURRENT COMPLAINTS

1. CONDITION :

1. Pain Level

2. CONDITION :

2. Pain Level

3. CONDITION :

3. Pain Level

4. CONDITION :

4. Pain Level

Other forms of treatment tried :

If yes, state what type of treatment :

Who provided it :

How long ago? :

What were the results?

Please Explain :

List ALL medications you are currently taking (prescribed AND over-the-counter) Including vitamins, birth control, pain remedies, etc.

Past History

Have you ever been diagnosed with any of the following conditions? Please check all that apply.

Social History

1. Smoking :

2. Alcoholic Beverage : consumption occurs

3. Recreational Drug use :

Family History

1. Does anyone in your family suffer the same condition(s)?

If yes, whom :

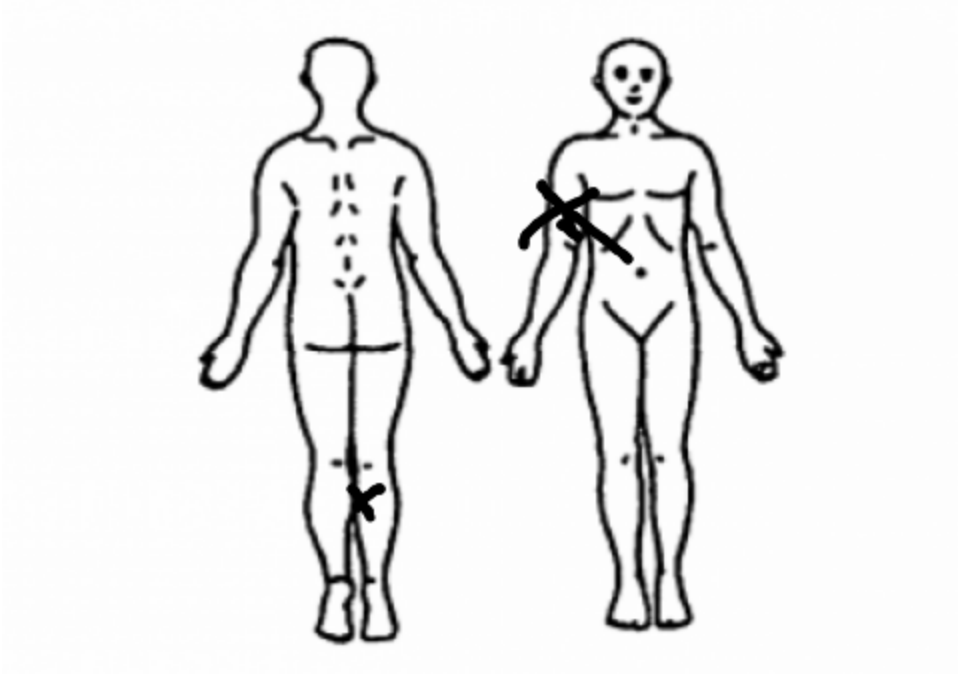
Have they ever been treated for their condition?

2. Any Hereditary conditions the doctor should be aware of ?

If yes, please explain

4. Hobbies - Recreational Activities - Exercise Regime : How does your present problem affect? (See ADL form)

Please MARK the Diagram to indicate your symptoms



What relieves your symptoms?

What makes your symptoms feel worse?

Is this the result of :

Auto Accident

Date of injury (If Known)

Please CHOOSE the number to indicate your FUNCTION for each category.

Family/Home Responsibilities

Recreation

Self Care

Life Support Activity

LIST ANY ACTIVITIES CURRENTLY RESTRICTED :

1.

2.

3.

LIST USUAL ACTIVITIES LEVEL :

1.

2.

3.

Identify any other injury(s) to your spine, minor or major, that the doctor should know about :

DOB :

Method of payment for today's charges:

Policy Holder :

Social Activity

Occupation

Health Insurance Company Name :

*I hereby authorize payment to be made directly to Dilliard Chiropractic P.C. for all benefits which may be payable under a healthcare plan or from any
other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and
further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to
Dilliard Chiropractic, P.C. for any and all services I receive at this office.

Patient or Authorized Person's Signature

Date

Tuesday, November 6, 2018

Doctor's Signature

Date

Tuesday, November 6, 2018

Dilliard Chiropractic P.C. • 531 N. Magnolia Ave • El Cajon, CA 92020 • (619) 447-2651