PATIENT APPLICATION FOR TREATMENT

TODAY'S DATE: _____ ACCT # _____

NAME: _____ HOW WOULD YOU LIKE TO BE ADDRESSED? _____

DATE OF BIRTH: _____ AGE: _____ GENDER: _____

YOUR ADDRESS: _____ CITY: _____

STATE: _____ ZIP: _____ SS #: _____ HOME #: _____

YOUR OCCUPATION: _____ WK #: _____

EMERGENCY CONTACT _____ PH #: _____ CELL #: _____

MARITIAL STATUS **S M W D**

HOW MANY CHILDREN DO YOU HAVE? _____ WHAT ARE THEIR AGES? _____

HAVE THEY OR ANY OTHER MEMBERS OF YOUR FAMILY RECEIVED CHIROPRACTIC CARE? ❑ Yes ❑ No

HAVE YOU EVER HAD CHIROPRACTIC CARE? ❑ Yes ❑ No HOW LONG HAS IT BEEN? _____

THE 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? _____

DO YOU HAVE ANY ALLERGIES? (SPECIFY): _____

HAVE YOU EVER SUFFERED FROM OR BEEN DIAGNOSED AS HAVING: (CIRCLE YES OR NO FOR EACH)

Y	N	*Broken or 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	Pacemaker	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

* Explanation: _____

WHEN WAS YOUR LAST PHYSICAL EXAM? _____

WHEN WAS THE LAST TIME YOU WERE INVOLVED IN AN ACCIDENT OF ANY KIND? _____

FOR DOCTOR'S USE ONLY

❑ GENERAL

INJURY TYPE:

❑ NDRA

DRUG ALLERGIES:

❑ SEE MEDS ADDENDUM

MEDICATION LIST

NAMES OF MEDICATION	NAMES OF VITAMINS	NON-Rx STRENGTH	Rx STRENGTH	DATE STARTED	DATE STOPPED	WHO PRESCRIBED DR. / SELF	
						D	S
						D	S
						D	S
						D	S
						D	S