APPLICATION FOR TREATMENT

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.

Date: _____

Name: _____ 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: _____

Who is responsible for your bill? ☐ Self ☐ Spouse ☐ Employer ☐ Insurance ☐ Other _____

How Payment will be made:

_____ Cash
_____ Check

Type of Insurance

_____ Workers' Comp.
_____ Credit Card

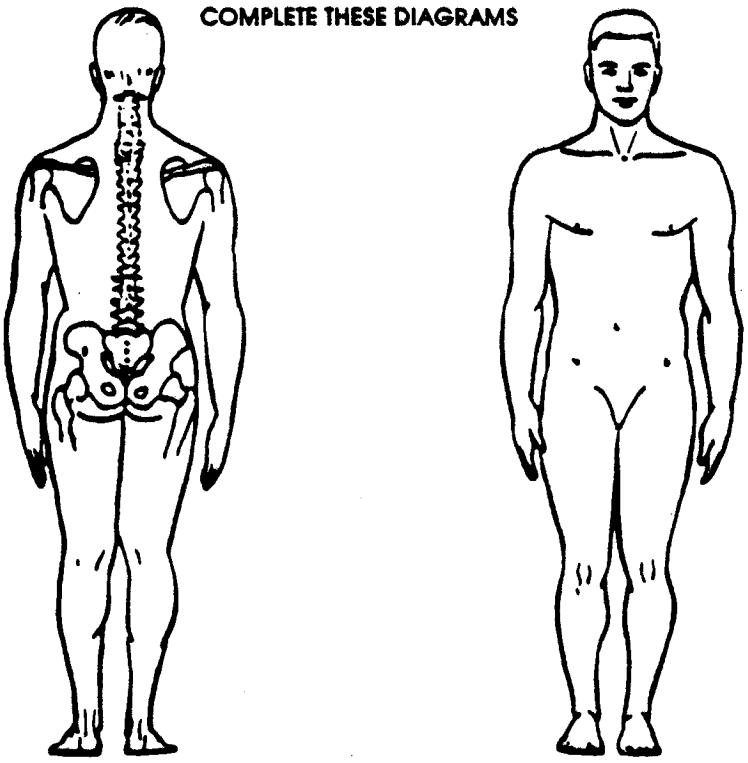
_____ Health Insurance
_____ Automobile Ins. Policy

Name of Company and Address _____

_____

If you are in pain, please mark the exact location of your pain on the diagram below. 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.

COMPLETE THESE DIAGRAMS



MAJOR COMPLAINT
(Please describe only your major problem)

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? _____

_____

_____

ANY CHIROPRACTOR CONSULTED IN THE PAST? Name: _____

Dates consulted: _____ For what problem? _____

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

(PLEASE COMPLETE REVERSE SIDE)