

Phillips Chiropractic Application for Treatment

General Information

Name : _____
Address : _____
City/Zip : _____
Birthdate : _____
Social Security # : _____
Home Phone # : _____
Cell Phone # : _____
Occupation : _____
Employer : _____
Work Phone # : _____
Spouse : _____
Spouse Employer : _____
Spouse Work # : _____
Emergency Contact : _____
Emergency Contact # : _____
Email Address : _____
Today's date : _____
Referred by : _____

Past Medical History

Surgeries and dates: _____

Fractures and dates: _____

Serious illnesses and dates: _____

Other injuries: _____

Any history of current complaints and dates: _____

Prior chiropractic treatment and dates: _____

Current Medical History

Current health problems/conditions _____

Current medications _____

Are you pregnant? Yes No

Chief Complaint

Describe any accidents, falls, etc. that may have caused your problems? _____

Have you ever had similar symptoms? Yes No

If yes, when and what treatment did you receive? _____

Please list other physicians that you have seen for this current condition?

When did they treat you and what, if any, was their diagnosis? _____

Has this problem been getting?

Better Worse Staying the same

What seems to make your condition feel better? _____

What seems to make your condition feel worse? _____

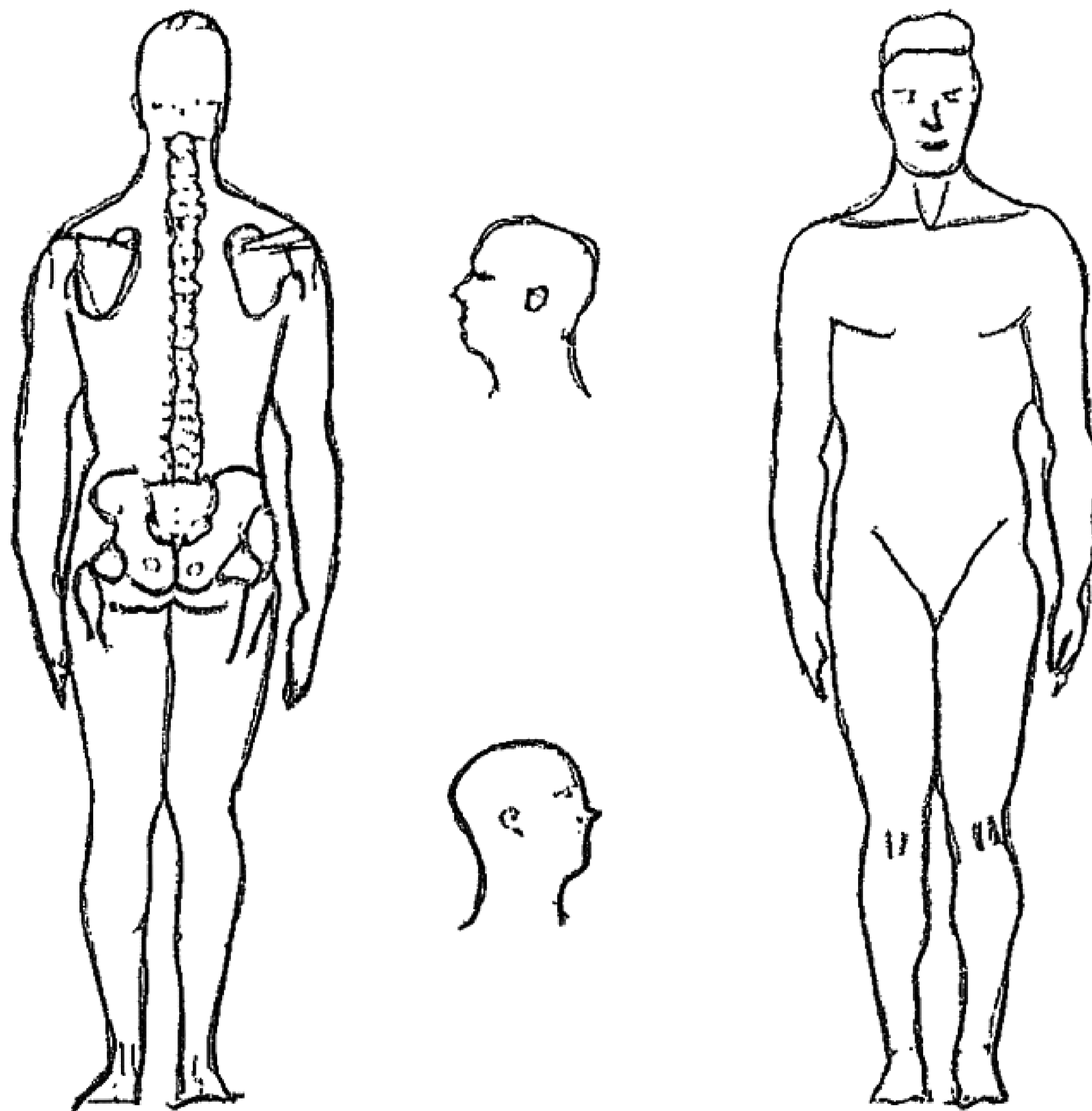
Rate your pain on a 1-10 scale with 10 being the worse: _____

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Using the diagram on the right, please indicate the exact location of your pain.

Using the diagram on the right, please indicate the type of pain you are experiencing (i.e. sharp, dull, radiating, constant, on/off, burning, aching, weakness, soreness, spasms, tightness, tenderness, tingling, numbness, etc.)

Due to your present condition, are you experiencing any limitations at work, home, or walking? If yes, what exactly are these limitations?



Financial Responsibility

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

What type of insurance do you want to file this on: Workers' Comp. Health Auto

What is your insurance company's name and address? _____

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

By signing below, I understand that all fees are payable at the time X-rays, examinations, and treatments are received, unless other written financial arrangements have been made in advance. I also understand that should an agreement between Phillips Chiropractic and me be needed in order to fulfill my responsibilities, I authorize Phillips Chiropractic to verify my credit history.

Patients
Signature _____

Social
Security# _____

Today's
Date _____