Application For Treatment

Date:_____ Account#:_____

Name:_____Date of Birth:_____

Address:_____City:_____State:_____Zip:_____

Home Phone:_____Work Phone:_____Cell Phone:_____

SS#:_____ Sex: M F Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

E-mail:_____ How were you referred?_____

Employer:_____Job description/duties:_____

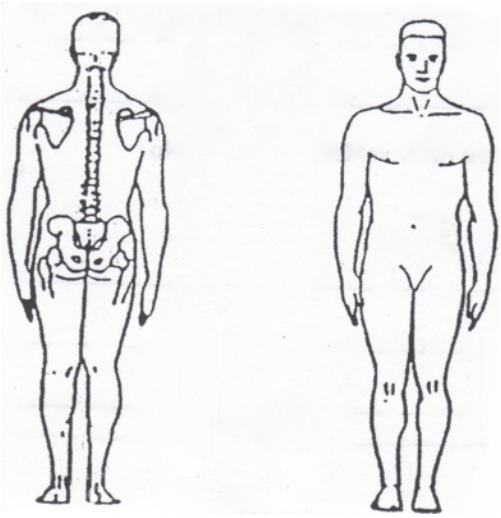
Name of Spouse:_____Employer:_____

Payment Method: ☐ Health Insurance (please provide insurance card) ☐ Medicare ☐ Cash/ Credit/ Check

Name on insurance card:_____ Relationship to Patient:_____

Date of Birth:_____ Phone:_____ Address:_____

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



Major Complaint:_____

_____

_____

_____

_____

How did this condition develop?_____

_____

Have you received any treatment for this condition? _____

If yes, when, where, and what kind of treatment? _____

_____

Have you ever had any auto accidents or other significant injuries? Please explain._____

_____

Have you ever had any surgeries? ☐ YES ☐ NO If yes, what type?_____

_____

List any medications or supplements you are currently taking. _____

_____

Are you pregnant? ☐ YES ☐ NO

Check any symptoms you have experienced.

☐ Headaches	☐ Migraines	☐ Numbness In Toes	☐ Face Flushed	☐ Feet Cold
☐ Neck pain	☐ Problems Sleeping	☐ Shortness Of Breath	☐ Irritability	☐ Hands Cold
☐ Neck stiffness	☐ Dizziness	☐ Stomach Upset	☐ Loss of Balance	☐ Fatigue
☐ Back Pain	☐ Head Seems Heavy	☐ Depression	☐ Fainting Spells	☐ Constipation
☐ Chest Pain	☐ Pins&Needles Arms	☐ Light Bothers Eyes	☐ Loss of Taste	☐ Cold Sweats
☐ Nervousness	☐ Pins&Needles Legs	☐ Loss of Memory	☐ Loss of Smell	☐ Fever
☐ Tension	☐ Numbness in Fingers	☐ Ears Ring	☐ Diarrhea	☐ _____

Have you ever been diagnosed with any of the following conditions?

☐ Diabetes	☐ Alcoholism	☐ Arthritis	☐ Ulcers	☐ Cancer
☐ High Blood Pressure	☐ AIDS/HIV	☐ Asthma	☐ Hepatitis A, B, C	☐ Fibromyalgia
☐ Heart Disease	☐ Anemia	☐ Epilepsy	☐ ADD/ADHD	☐ Tuberculosis
☐ Chronic Fatigue	☐ Allergies	☐ Other health issues or concerns: _____		

Do you smoke? ☐ YES ☐ NO Frequency_____

Do you exercise? ☐ YES ☐ NO If yes, how often? _____

How much water do you drink?_____ How often do you eat fruits/ vegetables?_____

How would you rate your current state of health on a 1-10 scale with 10 being optimal health?_____

Any health goals?_____

May our office send you Thank You cards, Birthday cards, or Newsletters? ☐ YES ☐ NO

May our office put your name on our Referral Board, when you refer a new patient? ☐ YES ☐ NO

May our office place your picture on our Patient Picture Board? ☐ YES ☐ NO

CONSENT TO CHIROPRACTIC CARE

I hereby authorize and release Chicoine Chiropractic and whomever he/she may designate as his/her assistants to administer treatment, physical examination, x-ray procedure, laboratory procedure, chiropractic care, massage, physical therapy or any clinic services that he/she deems necessary to my care. The treatment is designed to increase range of motion and decrease muscle spasms, thereby reducing pain levels among other desired results. As with any treatment there are risks, the most common are initial soreness and stiffness, tenderness, and inflammation. I have been informed that although good results are expected, each individual responds differently to treatment; therefore the outcome of the treatment has no guarantee. I give my consent with my signature below. If you have any further questions we are happy to answer them.

PROTECTED HEALTH INFORMATION (PHI) CONSENT AND AUTHORIZATION

Your PHI will be used by Chicoine Chiropractic or disclosed to others for purposes of treatment, obtaining payment, or support the day-to-day health care operations of this office. You may request a complete copy of the Notice of Privacy Practices from the Front Desk. I give my permission to this office to use and disclose my PHI in accordance with it. The above information is complete and accurate to the best of my knowledge.

_____

Patient Name

_____

Signature of Patient (or Legal Guardian) Date