

APPLICATION FOR TREATMENT

Date: _____

Name: _____ Date of Birth: _____

Address: _____ City _____ State _____ Zip Code _____

Home Phone#: _____ Work Phone #: _____ SS#: _____

Check if you are: Married Single Widowed Divorced

Where are you employed: _____

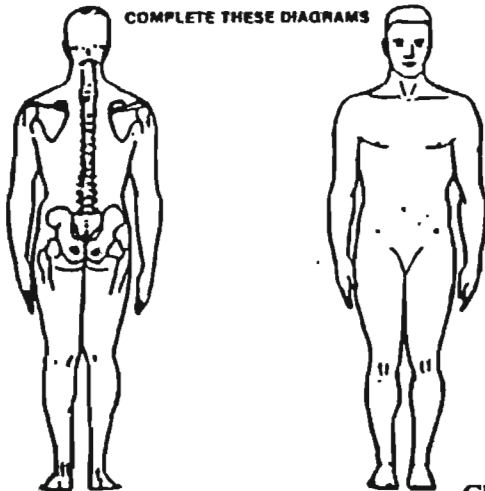
Name of Spouse: _____ Where employed: _____

HOW PAYMENT WILL BE MADE:

- Cash Health insurance (please provide insurance card) Automobile Insurance Policy
 Check Workers' Compensation Attorney

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 and on, when standing, when sitting, etc.,

MAJOR COMPLAINT



CHECK SYMPTOMS YOU HAVE NOTICED

- | | | | | |
|--|--|--|--|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Irritability | <input type="checkbox"/> Numbness in toes | <input type="checkbox"/> Face Flushed | <input type="checkbox"/> Feet Cold |
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Buzzing ears | <input type="checkbox"/> Hands Cold |
| <input type="checkbox"/> Neck stiff | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Stomach Upset |
| <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> Head seems heavy | <input type="checkbox"/> Depression | <input type="checkbox"/> Fainting spells | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Back pain | <input type="checkbox"/> Pins&Needles arms | <input type="checkbox"/> Light bothers eyes | <input type="checkbox"/> Loss of smell | <input type="checkbox"/> Cold sweats |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Pins&Needles legs | <input type="checkbox"/> Loss of memory | <input type="checkbox"/> Loss of taste | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Numbness in fingers | <input type="checkbox"/> Ears Ring | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> _____ |

How did this condition develop? _____

Have you received any treatment for this condition? If so, when and where? _____

Are you pregnant Yes No Drugs you now take _____

IF YOURS IS AN ACCIDENTAL INJURY, PLEASE COMPLETE THE FOLLOWING:

Date of Accident _____ Hour: ___ AM ___ PM Location: _____

Were you Driver Passenger Front seat Back seat (Right Side Middle Left) Pedestrian
Did any part of your body strike anything in the vehicle? Yes No If yes, what _____
At the time of impact were you: Looking straight ahead Looking to the left Looking up Looking to the right
 Looking down
Did airbag deploy? Yes No Were you knocked unconscious Yes No
Were you: Surprised by the impact Braced for the impact
Was the child restrained by: Car seat Booster seat Held in lap Restrained seatbelt
Was child thrown/ejected from their seat Yes No Has child been crying more since accident Yes No
Have you had problems sleeping since the accident Yes No
Were you Struck from behind Front Left side Right Side Head-on Were police notified Yes No
Driving conditions? Dry Wet Icy Other _____
Make/Model/Vehicle you were a driver or passenger in: _____
Make/Model/Vehicle of other person: _____
Were traffic citations issued to the driver of your vehicle? Yes No To the other vehicle Yes No
Was this work related? Yes No
Have you missed any days of work? Yes No If yes, Dates: _____
Job description/Duties _____
Any previous surgeries? _____

Name of Your insurance company & Policy Number _____
Driver's Name of the car you were in _____
Adjusters Name _____ Phone Number: _____ Claim#: _____
Name of other car's insurance & policy number _____
Driver's Name of other vehicle _____
Adjusters Name: _____ Phone Number: _____ Claim#: _____
Health Insurance Information _____
Attorney's Name: _____ Phone Number: _____

PROTECTED HEALTH INFORMATION ((PHI) CONSENT & AUTHORIZATION

Consent to use and disclosure of protected health information. Your PHI will be used by CTHC or disclosed to others for purposes of treatment, obtaining payment, or support the day-to-day health care operations of this office. You should review the Notice of Privacy Practices for a more complete description of how your PHI may be used or disclosed. You may request a copy of the Notice at the Front Desk. You may request a restriction on the use of your PHI. This office may or may not agree to restrict the use or disclosure of your PHI. I have reviewed this consent form and give my permission to this office to use and disclose my PHI in accordance with it.

Please check one: Yes No May our office send you thank you cards, occasional cards, newsletters/brochures
 Yes No May our office put your name on our referral board, when you refer
 Yes No May our office place your picture on our picture board

Signature of patient

Office Representative Signature

Date