

# 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: \_\_\_\_\_

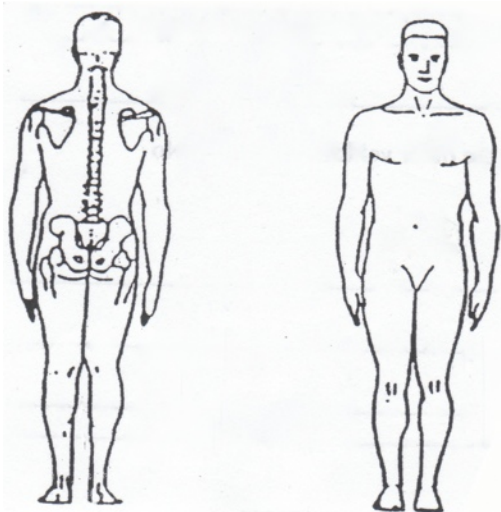
Name of Spouse: \_\_\_\_\_ Employer: \_\_\_\_\_

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? \_\_\_\_\_

List any medications or supplements you are currently taking. \_\_\_\_\_

Are you pregnant?  YES  NO

**Check any symptoms you have experienced.**

- |   |  |  |  |                                       |
|---|--|--|--|---------------------------------------|
| <input type="checkbox"/> Headaches      | <input type="checkbox"/> Migraines           | <input type="checkbox"/> Numbness In Toes    | <input type="checkbox"/> Face Flushed    | <input type="checkbox"/> Feet Cold    |
| <input type="checkbox"/> Neck pain      | <input type="checkbox"/> Problems Sleeping   | <input type="checkbox"/> Shortness Of Breath | <input type="checkbox"/> Irritability    | <input type="checkbox"/> Hands Cold   |
| <input type="checkbox"/> Neck stiffness | <input type="checkbox"/> Dizziness           | <input type="checkbox"/> Stomach Upset       | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Fatigue      |
| <input type="checkbox"/> Back Pain      | <input type="checkbox"/> Head Seems Heavy    | <input type="checkbox"/> Depression          | <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Chest Pain     | <input type="checkbox"/> Pins&Needles Arms   | <input type="checkbox"/> Light Bothers Eyes  | <input type="checkbox"/> Loss of Taste   | <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 Smell   | <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"/> _____        |

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

- |  |                                     |   |  |                                       |
|--|-------------------------------------|---|--|---------------------------------------|
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Arthritis                              | <input type="checkbox"/> Ulcers            | <input type="checkbox"/> Cancer       |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> AIDS/HIV   | <input type="checkbox"/> Asthma                                 | <input type="checkbox"/> Hepatitis A, B, C | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Anemia     | <input type="checkbox"/> Epilepsy                               | <input type="checkbox"/> ADD/ADHD          | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chronic Fatigue     | <input type="checkbox"/> Allergies  | <input type="checkbox"/> Other health issues or concerns: _____ |  |                                       |

Have you ever had any other significant injuries? Please explain. \_\_\_\_\_

Have you ever had any surgeries?  YES  NO If yes, what type? \_\_\_\_\_

**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 left  Looking up  Looking right  Looking down

Did the 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 the child thrown/ejected from their seat?  Yes  No Has child been crying more since accident  Yes  No

Were you:  Struck from behind  Front  Left side  Right Side  Head-on

Were police notified  Yes  No

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 \_\_\_\_\_

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