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:______________________

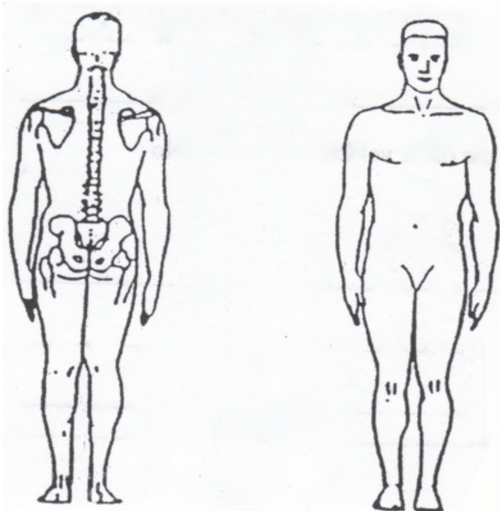
Name of Spouse:____________________________Employer:_______________________________________

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