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: _____

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

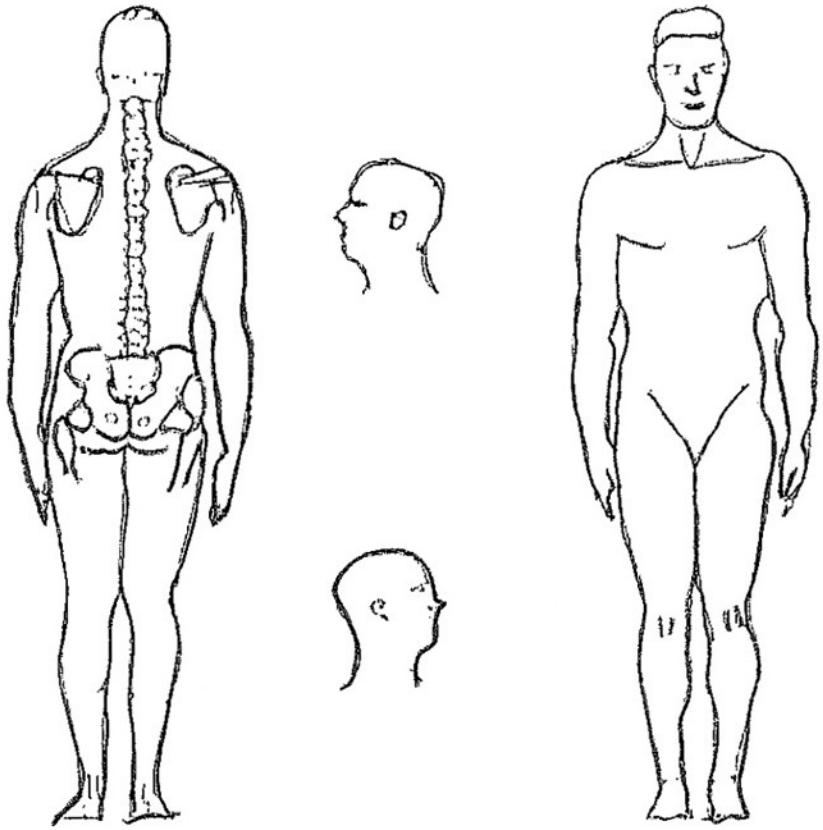
Using the diagram on the right, please indicate the type of pain you are experiencing (i.e. sharp, dull, radiating, constant, on/off, burning, aching, weakness, soreness, spasms, tightness, tenderness, tingling, numbness, etc.)

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_____