

Application for Treatment

Date _____

Name _____

Date of Birth _____

Address _____

Home Phone _____

City _____ State _____ Zip _____

Work Phone _____

S.S. # _____

Cell Phone _____

Driver's Lic # _____ St _____

Spouse's Cell _____

Marriage Status M S W D Sep

Spouse's Name _____

Email address _____

Occupation/Employer _____

Spouse's Occupation _____ Phone _____

Ages of children _____

Whom to call in an emergency _____ Phone _____

Nearest relative not living with you _____ Phone _____

Nearest friend not living with you _____ Phone _____

Who is financially responsible for your bill? Self Spouse Employer Insurance Other

How payment will be made: Cash Check Credit Card Worker's Comp. Health Ins. Auto Ins.

Name of Responsible Company and Address: _____

Who referred you to our clinic?

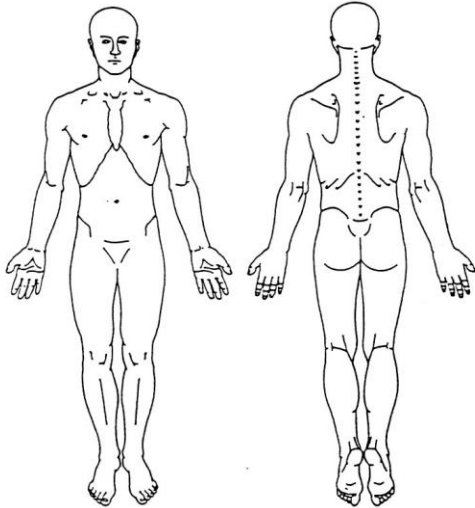
Friend _____

Google Yellow pages

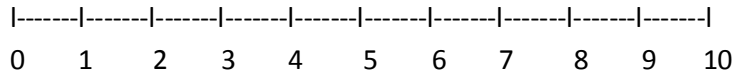
Facebook Newspaper

Other _____

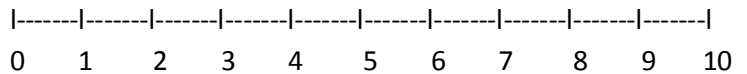
On the diagram please indicate the areas of pain.



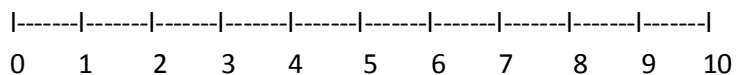
Please mark your current pain level on the scale:



When the pain is at its worst?



When the pain is at its best?



1. Please describe the condition that brings you in today: _____

How is this condition affecting your work, daily activities, sleep, etc? _____

When did you first notice this condition and how did it begin? _____

Pain duration _____ Does it radiate anywhere? _____

What relieves? _____ Aggravates? _____

Have you been treated for this before? When, where and what were the results? _____

Patient's Name _____

Have you had this problem before? Explain _____

Is your injury/sickness the result of an accident? Explain. _____

If so please describe the pain and/or symptoms:

1. At the time of the accident _____
2. 24 hours later _____
3. Presently _____

2. Please describe any secondary problems: _____

Pain duration _____ Does it radiate anywhere? _____

What relieves? _____ Aggravates? _____

3. Please describe other problems/health concerns: _____

Have you been treated by a chiropractor before? Dr.'s Name _____

What problem(s) did the chiropractor treat and what were the results? _____

When was your last physical examination? Dr.'s Name _____

Are you pregnant? Yes No Date of last menstrual period _____

Do you currently use tobacco products? Yes No How much? _____

Have you ever used tobacco products? Yes No

PAST HISTORY

Please list any diagnosed health conditions _____

Please list medications, past and present, and condition treated (including muscle relaxants, pain killers, birth control, cholesterol meds, etc.) _____

Please list any surgeries and describe outcomes _____

Have you been in an automobile accident? Past year Past 5 years Over 5 years Never

List any injuries sustained _____

List any medical conditions in your immediate family _____

Recent fractures/broken bones _____

Please list any other past injuries, accidents or health conditions _____

Fees are payable at the time Examination, X-rays, and treatment are performed, unless other arrangements are made in advance. X-rays are property of Bolz Chiropractic.

Patient's Signature _____

Date _____