Application for Treatment

Date _____

Name _____ Date of Birth _____
Address _____ Home Phone _____
City _____ State _____ Zip _____ Work Phone _____
S.S. # _____ Cell Phone _____
Spouse's Cell _____
Marriage Status M S W D Sep Spouse's Name _____
Email address _____
Occupation/Employer _____
Spouse's Occupation _____ Date of birth _____
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?

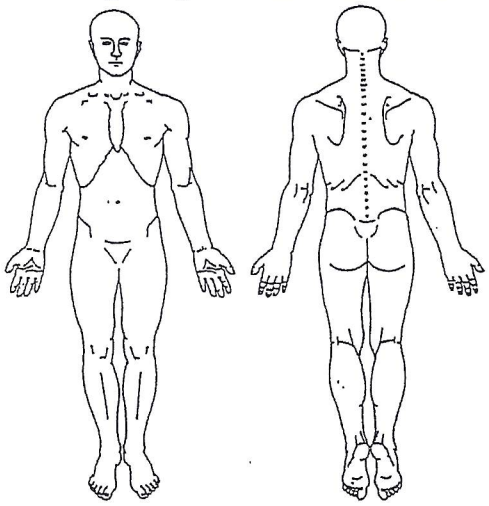
Friend _____

Google Yellow pages

Facebook Newspaper

Other _____

On the diagram please indicate the areas of pain.



Please mark your current pain level on the scale:

|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
0 1 2 3 4 5 6 7 8 9 10

When the pain is at its worst?

|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
0 1 2 3 4 5 6 7 8 9 10

When the pain is at its best?

|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
0 1 2 3 4 5 6 7 8 9 10

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? _____
_____

APP

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 _____