♦♦♦♦♦♦♦♦♦♦♦♦♦♦♦♦♦♦♦♦♦♦♦♦ APPLICATION FOR TREATMENT ♦♦♦♦♦♦♦♦♦♦♦♦♦♦♦♦♦♦♦♦♦♦♦♦

NIELSEN CHIROPRACTIC HEALTH CENTER

Please be as detailed as possible in willing out this application so we can best serve you as a patient. If you have any question or need any help, please ask the receptionist.

 PLEASE PRINT in black or blue ink.

♦♦♦ Chart Number: _____

♦♦♦

♦♦♦ Today's Date: _____

PATIENT DATA: Name: _____ Birth Date: _____
(Last) (First) (Middle)

Address: _____
(Physical & Mailing) (City, State, Zip)

Cell Ph #_____ Home Ph #_____ Work Ph #_____

Email Address: _____ DL#_____ State:_____

☐ Male ☐ Female AGE:_____ SS#_____ # of Children: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Other Preferred Language:_____

ETHNICITY: ☐ Hispanic/Latino ☐ NOT Hispanic/Latino ☐ Decline

RACE: ☐ White (Caucasian) ☐ Asian ☐ American Indian/Alaska Naive ☐ African American/Black
☐ Naive Hawaiian/Pacific Islander ☐ Decline

Emergency Contact:_____ Relationship:_____ Ph #_____

Smoking Status: Never / Former Smoker / Occasional / Everyday Smoker Smoking Start Date (optional):_____

OCCUPATION:_____ EMPLOYER:_____ Lbs. required to lit: _____lbs

How did you hear about us? ☐ Internet Site: _____ ☐ Clinic Location/Sign ☐ Phone Book: _____
☐ Person: _____ ☐ Radio Station: _____ ☐ Employer/DOT ☐ Newspaper: _____

Payment will be made by: ☐ Cash ☐ Check ☐ Credit Card ♦♦♦ Please file my INSURANCE: ☐ Health ☐ Automobile ☐ Work Comp

PRIMARY Insurance Co:_____ Name of Insured:_____

Insured's SS#: _____ Date of Birth: _____ Are you covered by more than one Insurance Co? Y / N

SECONDARY Insurance Co: _____ Name of Insured: _____ DOB: _____

MEDICAL HISTORY: Please check the corresponding box if you have had any of the following problems:

☐ Cancer	☐ Muscular Dystrophy	☐ Rheumatic Fever	☐ Diabetes	☐ Sinus Trouble
☐ Polio	☐ Multiple Sclerosis	☐ Scarlet Fever	☐ Loss of Bowel Control	☐ Asthma
☐ Tuberculosis	☐ Convulsions	☐ Nervousness	☐ Menstrual Cramps	☐ Anemia
☐ High Blood Pressure	☐ Epilepsy	☐ German measles	☐ Reproductive Disorders	☐ Numbness:
☐ Heart Trouble	☐ Concussion	☐ Digestive Disorders	☐ Poor Circulation	_____
☐ Chest Pain	☐ Arthritis	☐ Venereal Disease	☐ Kidney Disorder	☐ Other:
☐ Pacemaker	☐ Rheumatism	☐ Hepatis	☐ Bladder Trouble	_____

Date of last physical exam: _____ Have you been treated by a physician for any health condition in the last year? N / Y

Describe condition: _____

Have you ever had a metal implant? ☐ Yes ☐ No Have you ever been gunshot? ☐ Yes ☐ No

Surgery History: Condition: _____ Date: _____

_____ Date: _____

_____ Date: _____

Accident History: Job/Auto/Other: _____ Date: _____

Job/Auto/Other: _____ Date: _____

Job/Auto/Other: _____ Date: _____

Family History: (For example: CANCER / DIABETES / HEART TROUBLE / EMPHYSEMA / BACK PROBLEMS)

FATHER: _____

MOTHER: _____

SIBLINGS: _____

PLEASE DESCRIBE YOUR PRESENT MAJOR COMPLAINTS:

HEAD & NECK: _____

_____

MID-BACK/SHOULDERS: _____

_____

ARMS/HANDS: _____

_____

LOW BACK/HIPS: _____

_____

LEGS/FEET: _____

_____

OTHER: _____

My symptoms are worse: ☐Morning ☐Afternoon ☐Night ☐Always Have you ever had this before? ☐Yes ☐No
My symptoms: ☐Come and Go ☐Are constant ☐Came on Quickly
My symptoms developed from: ☐Job related injury ☐Auto accident ☐Illness ☐Gradual Onset ☐Other_____

Date started:_____ Where and how it occurred: _____

_____

What activity increases this condition?_____
What activity decreases this condition? _____
I have been using ☐Heat Packs ☐Ice Packs ☐Muscle Rub/Relaxer ☐Pain Meds: _____

Have you seen any other doctors for your present condition? If so, who and when:
1._____
2._____

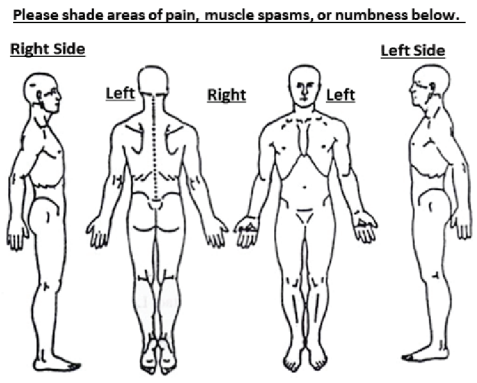
Are you allergic to any medications? □ Yes □ No Which ones? _____
Current list of medications and supplements: _____

_____

Women only: Are you pregnant? ☐Yes ☐No Date of last period: _____
If no periods, are you: ☐Post-Menopausal ☐Post-Hysterectomy ☐Other: _____

Symptoms of Spinal Cord Pressure: (Check all that apply)

☐Headaches - How often? _____
☐Dizziness
☐Blurred Vision
☐Concentration Loss / Confusion
☐Depression / Weeping Spells
☐Fatigue
☐Insomnia
☐Ringing in Ears
☐Fainting
☐Muscle Jerking
☐Low Resistance to colds



1 = Pain 2 = Tenderness 3 = Spasms 4 = Numbness

I understand that upon default of my account, I am subject to all reasonable collection costs, contingency based collection fees of 35% of the total owed, court fees and/or attorney's fees.

Patient or Guardian's Signature:_____ Date: _____