RETURN PATIENT APPLICATION

Personal Information

Name: _____ Today's Date: _____/_____/_____

Address: _____ City/State/Zip: _____

Home Phone: ( )_____ Cell Phone: ( )_____ E-mail Address: _____

Date of Birth: ____/____/____ Age: _____ Referred by: _____

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated Name of Spouse: _____

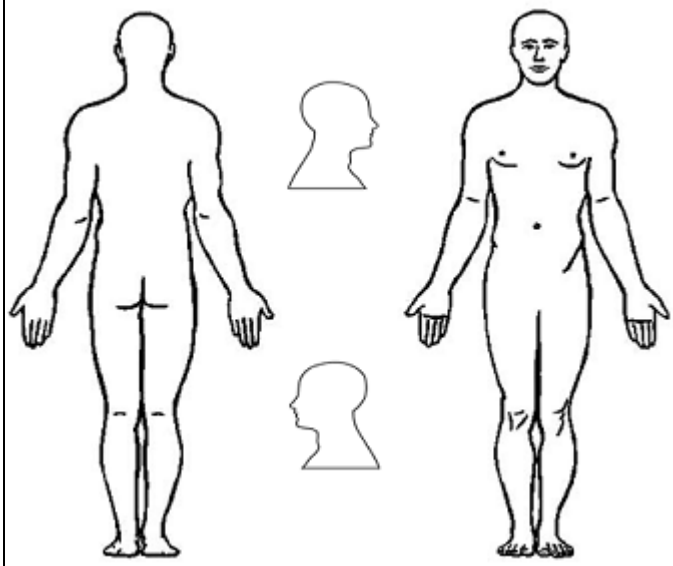
Employer's Name & Address: _____

Occupation: _____ Work Phone: ( )_____

What type of care do you desire? ☐ Temporary Relief ☐ Lasting Correction ☐ Best Care Possible

Current Conditions

Please circle the exact location of any pain you are experiencing:



In order of importance, list the health problems you are most interested in getting corrected:
1)
2)
3)
4)
5)
In order of severity, list those body functions that you are unable to perform, or that produce pain upon performance, i.e. walking, sitting, bending, etc.
1)
2)
3)
4)
5)
When was the first time you noticed these problems?

Describe any accidents, falls, injuries, sudden movements, etc. that may have caused these problems: _____

Have you had any similar health problems or injuries before? ☐ Yes ☐ No If yes, please explain:_____

Names of all other doctors you have seen for this problem: _____

Diagnosis and type of treatment you received (please include where and when you received treatment, as well as the results.) _____

Has your general health been ☐ Improving? ☐ Worsening? ☐ Staying the Same?

Please describe anything you do that improves your condition or worsens it: _____

Please check off and describe how this problem interferes with your work and/or personal life:

☐ Home activities effected:_____

☐ Work activities effected: _____

Have you missed any workdays? ☐ Yes ☐ No

☐ Recreational activities effected: _____

☐ Rest or sleep effected:_____

(Please Complete the Reverse Side)