

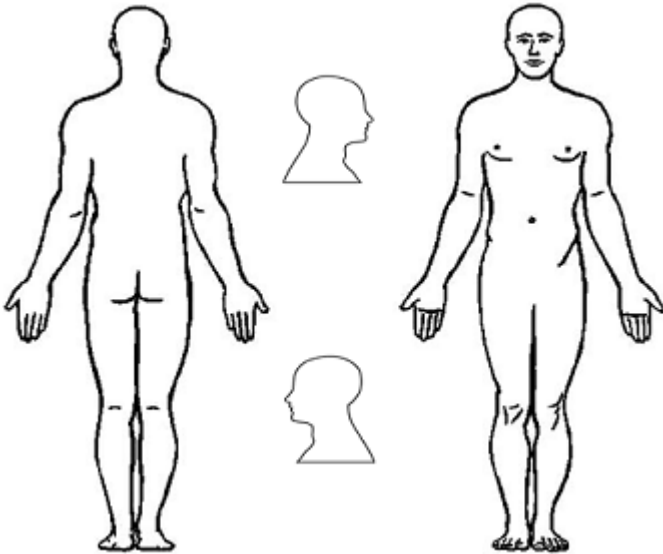
APPLICATION FOR TREATMENT

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)