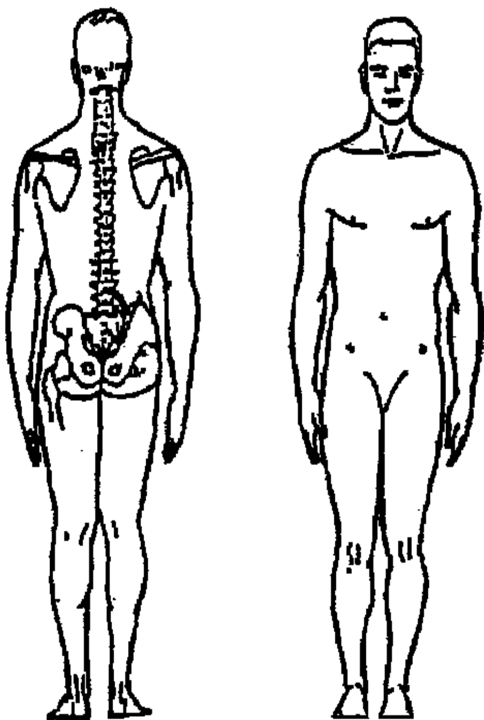
INFORMATION / APPLICATION FOR CARE

The following information is needed in order to better serve you. Please complete all questions. If you need help please ask the Chiropractic Assistant. (PLEASE PRINT.)

Today's Date ______________________

Name ________________________________ Cell Phone ______________ Home Phone ______________
Work Phone ____________________ E-Mail Address ____
Address ________________________________ City ________________ State ________ Zip __________
Age _____ Birth date ______________________ Marital Status: S M W D Number of Children _____
Your Employer _____________________________ Occupation ___________________ Years On Job ____
Employer Address _____________________________ City __________________ State _____ Zip ______

Name of Spouse or Parent ___________________________________ Their Birth date _______________
Spouse Employed By __________________________ Occupation __________________ Years On Job ____
Employer Address _____________________________ City __________________ State _____ Zip ______
Work Phone # ______________ Cell Phone ______________



COMPLETE THESE DIAGRAMS

If you are in pain, please mark the exact location of your pain on the diagram. Also describe the type and frequency of your pain, as well as any activity which brings on or aggravates the pain. For example; dull, sharp, consistent, off & on, when standing, when sitting, etc.

MAJOR COMPLAINTS

(Please list any condition you are being treated for or are experiencing.)

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Is your condition due to an accident? Yes _____ No _____
Date of accident? ____________________
Type of accident? Auto _____ Work/On Job _____
At Home _____ Other ________________________