

INFORMATION / APPLICATION FOR CARE



Get back into life.

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 _____ Home Phone _____ Work Phone _____

Cell Phone _____ E-Mail Address _____

Address _____ City _____ State _____ Zip _____

Age _____ Birth date _____ Marital Status: S M W D Number of Children _____

Please circle one payment type: Cash Check Master Card/Visa American Express

Your Employer _____ Occupation _____ Years On Job _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Your Social Security # _____

Do you have Medicare? Yes _____ No _____

Do you have Medicaid / Medical Assistance? Yes _____ No _____

Name of Spouse or Parent _____ Their Birth date _____

Spouse Employed By _____ Occupation _____ Years On Job _____

Employer Address _____ City _____ State _____ Zip _____

Office Phone # _____ Spouse's SS# _____

Does your spouse have health insurance at work? Yes _____ No _____

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.)

