

PATIENT APPLICATION FOR TREATMENT

TODAY'S DATE: _____ ACCT # _____
 NAME: _____
 DATE OF BIRTH: _____ AGE: _____ GENDER: _____
 YOUR ADDRESS _____ CITY: _____
 STATE: _____ ZIP: _____ SS #: _____ HOME #: _____
 YOUR OCCUPATION: _____ WK #: _____
 EMERGENCY CONTACT _____ PH #: _____ CELL #: _____
 MARITAL STATUS **S M W D** REFERRED BY: _____
 HOW MANY CHILDREN DO YOU HAVE? _____ WHAT ARE THEIR AGES? _____
 HAVE THEY OR ANY OTHER MEMBERS OF YOUR FAMILY RECEIVED CHIROPRACTIC CARE? Yes No
 HAVE YOU EVER HAD CHIROPRACTIC CARE? Yes No HOW LONG HAS IT BEEN? _____
 IS THIS VISIT FOR A WELLNESS CHECKUP? Yes No
 THE PURPOSE OR REASON FOR THIS APPOINTMENT? _____
 HOW OFTEN DO YOU DRINK ALCOHOLIC BEVERAGES? _____
 DO YOU SMOKE? Yes No HOW MUCH? _____
 DO YOU EXERCISE? Yes No HOW OFTEN? _____ TYPE? _____
 DO YOU HAVE ANY ALLERGIES? (SPECIFY): _____

HAVE YOU EVER SUFFERED FROM OR BEEN DIAGNOSED AS HAVING:

<input type="checkbox"/> Fractured bones	<input type="checkbox"/> Learning disability	<input type="checkbox"/> Upper back pain, stiffness	<input type="checkbox"/> High/low blood pressure
<input type="checkbox"/> Auto accidents	<input type="checkbox"/> Mood changes	<input type="checkbox"/> Mid back pain, stiffness	<input type="checkbox"/> Varicose veins
___ 0-1 years ago	<input type="checkbox"/> Congenital disease	<input type="checkbox"/> Lower back pain/ stiffness	<input type="checkbox"/> Liver trouble
___ 1-5 years ago	<input type="checkbox"/> Tumors	<input type="checkbox"/> Pain with cough, sneeze	<input type="checkbox"/> Gall bladder trouble
___ 5 years or more	<input type="checkbox"/> Neck pain or stiffness	<input type="checkbox"/> Hip pain R L	<input type="checkbox"/> Digestive problems
<input type="checkbox"/> Other accidents, falls	R L	<input type="checkbox"/> Headaches	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Numbness, tingling, pain in arms, hands, fingers	<input type="checkbox"/> Ruptures	<input type="checkbox"/> Hemorrhoids
<input type="checkbox"/> Diabetes	R L	<input type="checkbox"/> Coughing blood	<input type="checkbox"/> Prostate problems
<input type="checkbox"/> Convulsions, epilepsy	<input type="checkbox"/> Jaw pain or click (TMJ) R L	<input type="checkbox"/> Numbness, tingling, pain in buttocks, legs, feet, toes R L	<input type="checkbox"/> Impotence
<input type="checkbox"/> Skin problems	<input type="checkbox"/> Difficulty in excessive standing, sitting, riding, bending, lifting, twisting	<input type="checkbox"/> Foot trouble R L	<input type="checkbox"/> Kidney trouble
<input type="checkbox"/> Cancer *explain	<input type="checkbox"/> Shoulder pain R L	<input type="checkbox"/> Chest pain, asthma	<input type="checkbox"/> Menstrual problems, PMS
<input type="checkbox"/> Frequent colds, flu	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Heart problems R L	<input type="checkbox"/> Pregnant (now)
<input type="checkbox"/> Depressed	<input type="checkbox"/> Ringing in ears R L	<input type="checkbox"/> Stroke	<input type="checkbox"/> Bedwetting
<input type="checkbox"/> Irritable	<input type="checkbox"/> Hearing loss		<input type="checkbox"/> Ear infections
<input type="checkbox"/> Anemia	<input type="checkbox"/> Blurred/double vision		<input type="checkbox"/> AIDS, HIV
<input type="checkbox"/> Allergy, sinus			<input type="checkbox"/> Alcoholism
<input type="checkbox"/> Under stress			<input type="checkbox"/> Drug addiction
<input type="checkbox"/> Eating disorders			
<input type="checkbox"/> Trouble sleeping			
<input type="checkbox"/> Trouble concentrating			

FOR DOCTOR'S USE ONLY

GENERAL

INJURY TYPE:

NDRA

DRUG ALLERGIES:

*EXPLANATION: _____

WHEN WAS YOUR LAST PHYSICAL EXAM? _____
 WHEN WAS THE LAST TIME YOU WERE INVOLVED IN AN ACCIDENT OF ANY KIND? _____
 WHAT SURGERIES HAVE YOU HAD? _____
 WHAT ARE YOUR HEALTH GOALS? _____

MEDICATION LIST

NAMES OF MEDICATION	NAMES OF VITAMINS	NON-Rx STRENGTH	Rx STRENGTH	DATE STARTED	DATE STOPPED	WHO PRESCRIBED	
						DR.	SELF
						D	S
						D	S

SEE MEDS ADDENDUM

PLEASE WRITE ON BACK IF NOT ENOUGH ROOM.

ACCT: _____

PATIENT: _____

PATIENT HISTORY

1. What is your main complaint? _____

2. On the scale below, please circle the severity of your main complaint (At it's worst)

None	Slight	Mild	Moderate	Severe
1	2	3	4	5

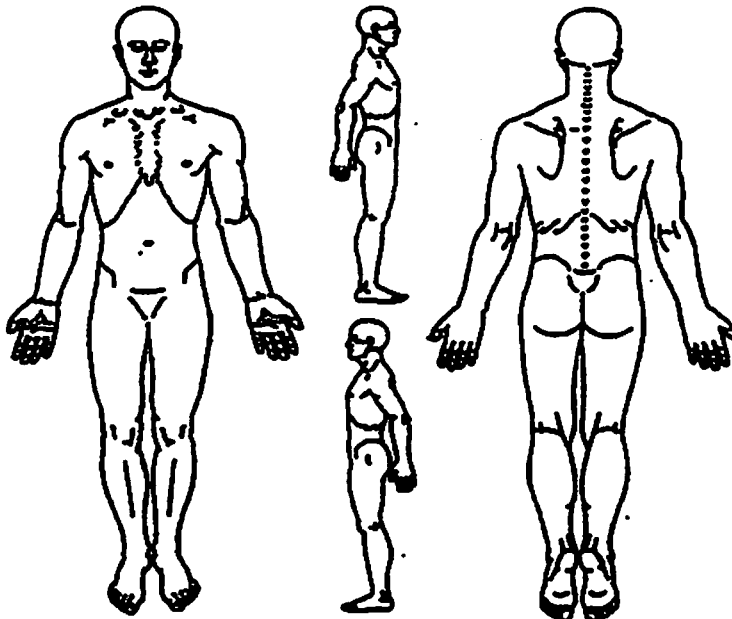
3. On the scale below please circle the percentage of time you experience your main complaint:

Occasional	Intermittent	Frequent	Constant
10	20	30	40
50	60	70	80
90	100	%	

4. How long have you been experiencing your main complaint? _____

5. On the diagram below, please show where you are experiencing all of your present complaints using the following letters:

A: ache B: burning pain C: cramping D: dull pain R: throbbing pain N: numbness T: tingling



Do you have pain and/or difficulty performing any of the following activities: (Check)

personal care _____

lifting _____

reading _____

concentrating _____

work _____

driving _____

sleeping _____

recreation _____

walking _____

sitting _____

standing _____

social life _____

Signature: _____

Date: ___/___/___

6. When do you notice it most? AM PM
 How long does it last? _____ Mins _____ Hrs
7. What makes it feel better? _____
8. What makes it feel worse? _____
9. Have you ever had this problem in the past? Yes No
10. I have been hospitalized been treated by another chiropractor
 been treated by another specialty provider never received care for this problem.
11. Have you lost time from work because of it? Yes No
 Dates? _____ to _____
12. Are you Pregnant? Yes No
13. What was the first day of your last menstrual cycle? _____
14. Number of pregnancies? _____ Miscarriages? _____

United Chiropractic Office Policies
(revised 2/05)

X-Ray Consent

The purpose of the x-ray examination to be performed is to analyze the spine for evidence of vertebral subluxation, rate and level of degeneration of the spine, and to determine the appropriateness of spinal adjustments. If the doctor discovers a non-chiropractic "unusual finding" when reviewing the x-rays, I will be informed. I thus must determine if I should seek the services of an additional healthcare provider for advice, diagnosis, or treatment of the unusual finding. I understand that seeking advice from another healthcare provider should not interfere with the subluxation correction care provided by this office.

I fully understand the above and consent to chiropractic spinal x-rays.

Patient Signature _____ Date _____

Pregnancy Release

This is to certify that to the best of my ability I am not pregnant and United Chiropractic has my permission to perform an x-ray evaluation. I understand the risks of an x-ray to an unborn child.

Date of last menstrual period _____

Patient Signature _____ Date _____

INSURANCE INFORMATION

COMMERCIAL INSURANCE AND MEDICARE ONLY

<i>Primary Insurance Company Name</i>			<i>Complete only if patient is not the insured</i>		
Type	Group	Private	Insured's Name _____		
Membership/Cert # _____			M F Married Single Widowed Divorced		
Policy/Group # _____			Patient's Relationship to Insured _____		
			Insured's Date of Birth ____/____/____		
			Insured's Employer _____		
<i>Secondary Insurance Company Name</i>			Insured's Name _____		
Type	Group	Private	M F Married Single Widowed Divorced		
Membership/Cert # _____			Patient's Relationship to Insured _____		
Policy/Group # _____			Insured's Date of Birth ____/____/____		
			Insured's Employer _____		

RELEASE AND ASSIGNMENT

I authorize release of any information necessary to process my insurance claims and assign and request payment directly to my physicians.

Patient's Signature _____ Date _____

Financial Agreement:

Payment is expected on the date that services are rendered.

Insurance filing is a courtesy for our patients. Balance for services is the patient responsibility.

I understand any outstanding accounts beyond 90 days may result in a 25% (twenty-five) finance charge per month. If the account is sent to collections additional charges will be billed to the patient. (according to Collection Agency fee amounts.)

Patient Signature _____ Date _____