APPLICATION FOR CARE AT DYKER HEIGHTS FAMILY CHIRORACTOR

PATIENT INFORMATION

Name: _____Birth Date: ___/___/____ Age: ____Sex: M__ F__

Address: _____City: _____State: _____ Zip: _____

E-mail Address: _____ Home Phone: _____

Mobile Phone: _____ Work Phone: _____

Employer: _____

Occupation: _____

Significant other's Name: _____

Who referred you to our office?

_____

HISTORY OF COMPLAINT

Please identify if you came to this office, not as a result of a complaint, but for wellness care by completing the following:

Your Goals of Care:

_____

Please list, if any, complaints, injuries or illnesses that brought you to this office:

When did these problem(s) begin? _____ Is your problem(s) the result of ANY type of accident. ___Yes ___ No

If yes identify type: __Auto __Work __Home __Other (please explain):_____

Date of Accident _____

Have you suffered with any of this or a similar problem(s) in the past? __ No __ Yes

If yes, When_____

Please state what type of treatment you have tried for this problem(s):

_____

Are you currently taking any medications? PLEASE LIST:

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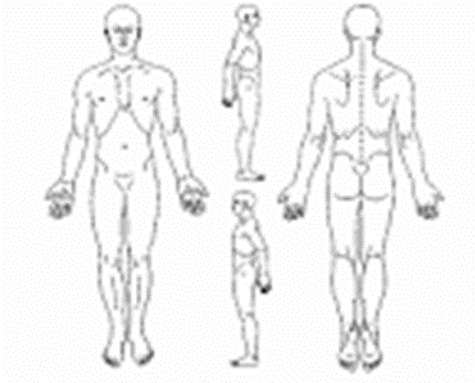
*PLEASE MARK the areas on the Diagram with the following letters to describe

your symptoms: R=Radiating B=Burning D=Dull A=Aching S=Sharp/Stabbing T=Tingling N=Numbness



On a scale of 1 to 10 with 10 being the worst pain and 0 being no pain:

Rate how you feel today (Circle the #): 0 – 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

What percentages of the day do you experience symptoms: _____%

What relieves your symptom(s)?

_____

What makes them feel worse?

_____

Have you had previous chiropractic care? __ Yes __ No

PAST HISTORY

If you have ever been diagnosed with any of the following conditions please indicate with a

P for in the Past, C for Currently have and N for Never have had a:

[ ] Disability [ ] Broken Bone [ ] Fracture [ ] Dislocations [ ] Tumors [ ] Diabetes

[ ] Heart Attack [ ] Rheumatoid Arthritis [ ] Osteoarthritis [ ] Cerebral Vascular

[ ] Other serious conditions:

_____

PLEASE, identify ALL PAST and any CURRENT conditions you feel may be contributing your present problem:

_____

SOCIAL HISTORY

1. Smoking: __cigars __ pipe __ cigarette . How often? __ Daily __Weekends __Occasionally __ Never

2. Alcoholic Beverage: consumption occurs __ Daily __ Weekends __ Occasionally__ Never

3. Recreational Drug use: __ Daily __Weekends __ Occasionally __ Never

FAMILY HISTORY:

1. Does anyone in your family suffer with the same condition(s) you currently have?__ No __ Yes
   If yes, who:_____

Have they ever been treated for their condition? __ No __ Yes __I don't know

2. Any other hereditary conditions the doctor should be aware of. __No __Yes:

_____

I hereby authorize payment to be made directly to DYKER HEIGHTS FAMILY CHIRORACTOR for all benefits which may be due and payable under insurance coverage for the above named patient. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments. I further acknowledge that this assignment of benefits does not in any way relieve me of liability and that I will remain financially responsible to Corrective Care Chiropractic.

I request the clinic to submit claims to this insurance company:

_____.

Please provide your insurance card to us for copying. We will determine eligibility.

_____ _____

Patient or Authorized Person's Signature Date

CONSENT TO TREAT A MINOR

MINOR PATIENT'S NAME: _____

The risks associated with exposure to ionization, and spinal adjustments have been explained to me to my complete satisfaction, and I have conveyed my understanding of these risks to the doctor, and after careful consideration I do hereby request, and authorize Corrective Care Chiropractic to perform imaging studies, and chiropractic adjustments, to my minor child, for whom I have the legal right to select, and authorize health care services on behalf of.

__Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse /former spouse or other guardian is not required. If my authority to so select and authorize this care should change in any way I will immediately notify this office.

Guardian Signature Date