PATIENT APPLICATION FOR TREATMENT

Last name:	First:	MI:	Gender ☐ M ☐ F

Email:	Date of Birth:	Age:
Your address:	City:	State:

Zip:	SS#:	Home #	Cell #

Prior Occupation: Present Occupation:	Wk #
Marital status? Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow(er) ☐	
Emergency Contact?	Emergency Phone #
How many children do you have? What are their ages?	
Have you ever had chiropractic care? ☐ Yes ☐ No How long has it been?	
Has anyone else in your family ever had chiropractic care? ☐ Yes ☐ No	
Do you smoke: ☐ Yes ☐ No How much?	Do you exercise: ☐ Yes ☐ No How much?
What is the purpose or reason for this appointment?	
When do you notice it most? ☐ AM ☐ PM	Have you ever had this in the past? ☐ Yes ☐ No
What makes it feel better?	What makes it feel worse?
(Females only) Are you pregnant? ☐ Yes ☐ No	

Using the scale below, indicate the **severity** of your **main complaint** (when at its worst)

None		**Slight**		**Mild**		**Moderate**			**Severe**
1	2	3	4	5	6	7	8	9	10

Using the scale below, indicate the **percentage of time** you experience your **main complaint**:

		Occasional		**Intermittent**		**FREQUENT**			**CONSTANT**	
0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%

How long have you been experiencing your **main complaint**?

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