



APPLICATION FOR TREATMENT

** required field*

| | | | |
|--|-----------------|---|-------------------|
| *Name | | *Date | |
| *Address | | | *Birthdate |
| *City | | *State | *Zip |
| *Phone - Home | Phone - Evening | Phone - Cell | |
| Have you had treatment for this problem before? <input type="checkbox"/> No <input type="checkbox"/> Yes | | | |
| If yes, by <input type="checkbox"/> Physician <input type="checkbox"/> Chiropractor <input type="checkbox"/> Physical Therapist <input type="checkbox"/> Osteopath Other: | | | |
| What did they do and/or recommend? | | | |
| When did your symptoms appear? | | Is this condition progressively worse? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure | |
| Is it <input type="checkbox"/> constant, or <input type="checkbox"/> come and go? Does it interfere with <input type="checkbox"/> work <input type="checkbox"/> sleep <input type="checkbox"/> daily routine <input type="checkbox"/> recreation? | | | |
| Activities that are painful to perform: <input type="checkbox"/> Sitting <input type="checkbox"/> Walking <input type="checkbox"/> Bending <input type="checkbox"/> Lying Down Other: | | | |
| Occupation: | | | |

Do you take: Muscle Relaxers Pain Killers Insulin Birth Control Pills Hormones Heart/BP Meds?
 Over-the-counter pain relievers Over-the-counter cold/sinus medication Diet Pills?

Please list all medications and supplements in the boxes at the bottom of the page.

| | | |
|----------------------|--------------|--------------------------|
| Date of last: | | |
| Physical Exam | Blood Tests | Urine Test |
| Spinal Exam | Spinal X-Ray | Chest X-Ray |
| Dental X-Ray | Bone Density | MRI, CAT Scan, Bone Scan |
| Blood Type: | | |

Do you wear: Heel Lifts Shoe Lifts Arch Supports Orthotics Describe:

Significant accidents/falls and dates:

Allergies:

Conditions *Check conditions you have or have had in the past*

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|--|--|---|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Macular degeneration | <input type="checkbox"/> Scarlet fever |
| <input type="checkbox"/> Allergies/Allergy shots | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Migraine headaches | <input type="checkbox"/> Smoker, past/present |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Fractures | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Suicide attempt |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Goiter | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Mumps | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Bleeding disorders | <input type="checkbox"/> Gout | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Breast lump | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tumors, growths |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Typhoid fever |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Herniated disc | <input type="checkbox"/> Polio | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Prostate problem | <input type="checkbox"/> Vaginal infections |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Prosthesis | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Chemical dependency | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Psychiatric care | <input type="checkbox"/> Whooping cough |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> Other |

Medications, Vitamins, Minerals, Herbs, Enzymes *List everything currently taking*

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