

# Application For Treatment

Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_

It is important that you answer all of the questions that apply to you to the best of your knowledge. If you have any questions or need assistance please let us know.

Last Name: \_\_\_\_\_ Name you wish to be called by: \_\_\_\_\_

First Name and Initial: \_\_\_\_\_, Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_, Sex \_\_\_\_

Address: \_\_\_\_\_, City/State/Zip: \_\_\_\_\_

Mailing Add: \_\_\_\_\_, City/State/Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_, E-Mail: \_\_\_\_\_

If no home phone, please give a number where we can leave a message or contact your family)

Cell Phone: \_\_\_\_\_, Cell Phone Carrier: \_\_\_\_\_

Social Security # \_\_\_\_\_, Driver's Lic. # \_\_\_\_\_ State \_\_\_\_\_

Height \_\_\_\_\_, Weight \_\_\_\_\_, Marital Status  S  M  D  W

Name and address of nearest relative not living with you: \_\_\_\_\_

Name and address of a close friend: \_\_\_\_\_

I prefer to handle my account :  Insurance  Cash/Check  Credit Card

If a person other than the patient is responsible for payment of the account, please give that person's name address and phone number ;

Patient's or Responsible Party's Occupation : \_\_\_\_\_

Work Phone ; \_\_\_\_\_, Employed by ; \_\_\_\_\_

Spouse's Name ; \_\_\_\_\_, Spouse's Occupation; \_\_\_\_\_

Spouse's Employer; \_\_\_\_\_, Work Phone : \_\_\_\_\_

Tell us how you heard about our office: \_\_\_\_\_

(If a friend or family member referred you, give us their name and address so we may thank them for referring our services.)

Fees are payable at the time of service, (X-rays, exams, treatments, etc.), X-rays remain the property of this clinic.

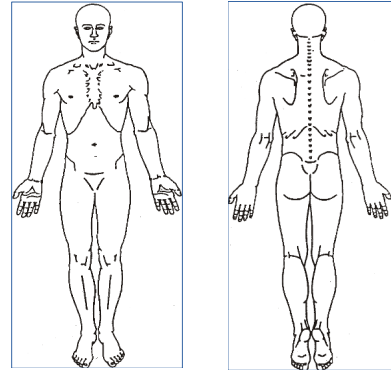
All Information Is Correct To The Best Of My Knowledge.

Signature : \_\_\_\_\_

**Emerald Shores Chiropractic, LLC. 1101 Ohio Ave, Lynn Haven, FL 32444 (850) 265-6163**

Please describe your pain in your own words. If you are in pain, indicate on the figures at the right exactly where the pain is located.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



How long have you had this problem? \_\_\_\_\_

Is this visit due to an accident? If so, tell us what type, (auto, work, etc.) And when it occurred. Please describe in your own words how it happened.

\_\_\_\_\_  
\_\_\_\_\_

Are you pregnant?  Yes  No

List all medications you are now taking : \_\_\_\_\_

List any allergies: \_\_\_\_\_

Are you wearing:  Heel lifts  Sole lifts  Inner soles  Arch support  Dentures  Artificial limb

To your knowledge, have you any metal in your body? (Ex: surgical wire, implants, metal fragments that haven't been removed)?  Yes  No

Have you been in an auto accident?  past yr  5 yrs  Over 5 yrs  Never

Any other personal injury or accident?  1 yr  5 yrs  Over 5 yrs  Never

Briefly describe : \_\_\_\_\_

Have you been treated for a spinal disorder?  Yes  No

Have you ever had chiropractic care before?  Yes  No

If yes : Name of Doctor: \_\_\_\_\_

Treated for : \_\_\_\_\_

Were you satisfied with care?  Yes  No

Have you ever: Been knocked unconscious?  Yes  No

Used a cane, crutch, etc. ?  Yes  No

Had a fractured bone ?  Yes  No

Been hospitalized for other than surgery ?  Yes  No

List surgical operations you have had and approximately when: \_\_\_\_\_

Do you take vitamins ?  Yes  No

Do you feel you may need vitamins ?  Yes  No

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