

HUDSON FAMILY CHIROPRACTIC

Application for Treatment

Confidential Patient Information

How did you decide to come to our office? _____

Referred By: _____

Is your visit due to an accident? Yes _____ No _____

(If yes, please complete separate form in office)

Patient Data

Name _____ Phone # _____

Address _____ City _____ State _____ Zip _____

Age _____ Birthdate _____ Martial Status _____ # of Children _____

Occupation _____ Employed By _____

Business Address _____

Work Phone _____ Email Address _____

Emergency Contact _____ Phone _____

Spouse's Name _____ Phone _____

Present Complaint

Describe your reason for coming to our office today _____

Since the time of this (these) complaint(s) began, what, if anything, have you tried that **did not** work? _____

Has the problem interrupted your sleep? ___ Yes ___ No How: _____

Have you seen any other doctors for this problem? ___ Yes ___ No

Doctor's Name _____

Were you hospitalized? Yes _____ No _____ How many days? _____

What hospital? _____ Number of work days missed _____

Have you been to a chiropractor before? ___ Yes ___ No

If yes, date of your last visit _____

Medical History

___ Generalized pain ___ Diabetes ___ Rheumatism ___ Tremors ___ Muscle Spasm

___ Concussion ___ Anemia ___ Asthma ___ Arthritis ___ Heart Trouble

___ Convulsions ___ Cancer ___ Nose Bleeds ___ Dizziness ___ Epilepsy

___ Numbness ___ Neuritis ___ Faintness ___ Joint Pain ___ Joint Swelling

___ Backaches ___ Headaches ___ Sinus Trouble ___ High Blood Pressure

___ Muscular Dystrophy ___ Benign bone tumor

___ Bleeding Disorder ___ Osteoporosis

___ Anticoagulant therapy Other _____

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Previous Care

Surgeries _____ When? _____

Have you been treated by a doctor in the last 12 months? Yes No

Describe Condition _____

Date of last complete physical exam _____

Are you pregnant? _____

Patient Agreement

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature: _____ Date: _____

Spouse or Guardian Signature: _____ Date: _____

If your injury is the result of an accident please complete a separate accident form.