Horning Chiropractic Center, P.A.

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APPLICATION FOR TREATMENT

Date: _____

Please check the type of care desired: _____Temporary Relief _____Lasting Correction

_____Check here if you want the Doctor to select the type of care he feels is best for you

Name:_____Date of Birth: _____

Address:_____City:_____State:_____Zip:_____

Home Phone:_____ Cell Phone: _____

Work Phone: _____

E-mail address: _____

Check if you are : _____Married_____ Single_____ Widowed_____ Divorced_____ Separated

Name of husband or wife:_____ Ages of Children: _____

Where are you or husband/wife employed? _____

Referred to our office by: _____

Who is responsible for your bill?_____ Self _____Insurance_____ Other

How Payment will be made?:

_____Cash_____Health Insurance_____Check _____Credit Card

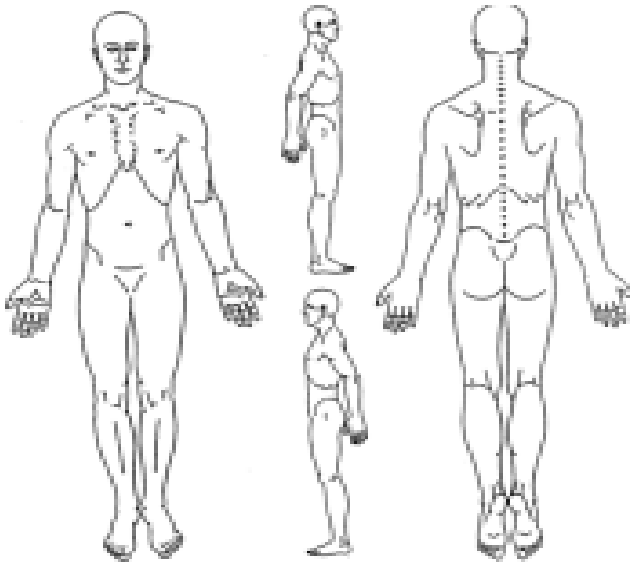
Name of Insurance Company : _____

Is your visit a result of an auto or work related accident?□ Yes□ No If yes, what was the date of your accident. :

_____

If you are in pain, please mark the exact location of your pain on the diagram below.

COMPLETE THESE DIAGRAMS



MAJOR COMPLAINT

(Please describe your major complaints)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

How did this condition develop? (What caused it? How did it start?)_____
_____
When was the very first time you were aware of this problem?: _____
Have you ever had this problem or similar problem before? If yes, please explain: _____
_____
Have you ever received any treatment for this condition? If yes, where and when, and what were your results?:_____
_____
Has this problem been getting better, worse, or staying the same?:_____
Is there anything you do that makes your condition worse? :_____
_____

How has this condition affected your:
A. Home life? _____
B. Occupational life?_____
C. Recreational life? _____
D. Rest and sleep life?_____

Have you ever been in an automobile accident? _____Past year_____ Past 5 years _____Over 5 years _____Never

ANY ACCIDENTS, FALLS, ETC. THAT MIGHT HAVE CAUSED YOUR PROBLEM?_____
_____

ANY MEDICAL DIAGNOSIS FOR YOUR COMPLAINT? _____
_____

What surgery has been done?_____

Drugs you now take: ___Nerve Pills____Pain Killers____Muscle Relaxers____Anti-Depressants___Tranquilizers
____Insulin____ Birth Control____ Other (pleaselist):_____

ANY CHIROPRACTOR CONSULTED IN THE PAST? Name: _____
Dates consulted:_____For what problem? _____

Fees are payable at the time x-rays, examinations, and treatments are received, unless other arrangements are made in advance. X-rays remain the property of this clinic.

Patient's signature: _____

Social Security No.-_____Date:_____