FIDEL CHIROPRACTIC CENTER

APPLICATION FOR TREATMENT

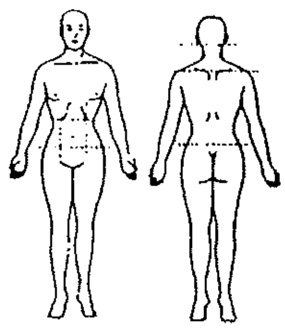
I am looking for: Lasting correction Temporary Relief Date ___________________
Referred to our office by: ____

Name ____ **Date of Birth** ____________________
E-mail ____
Address ____
City____ ST _____________________Zip____________________
Phone: H) ____________________ W) ______________________ **Cell)** __________________________
Occupation ___________________________________ Employer ______________________________________
Married Single Widowed Divorced Separated Ages of Children ______________________
Spouse name ___________________________________ Employer _____________________________________
Height: ______________ Weight: _________________ Sex: Male Female

In case of Emergency notify: _________________________________ Phone _________________
*(**Women only**) Are you pregnant? yes no Nursing? yes no*
Onset date of last menstrual cycle __________________________
Who is responsible for your bill? Self Spouse Employer Insurance ___________________

Major Complaint

____
____
____
____
____
____
____
____
____



Mark the area of your pain

Rate your level of pain: 0 1 2 3 4 5 6 7 8 9 10
None Mild Moderate Severe Horrible

How did this condition develop? What caused it? ____
____
Have you ever had this problem before? When? ____
Have you had any prior treatment for this condition? Where? _____________________________________
____
What makes your condition worse? ____
____
What makes your condition better? ____
____
Is this condition getting better, worse or staying the same? ___________________________________

How has this condition affected your life?

A. Home life ____
B. Occupational life ____
C. Recreational life ____
D. Rest and Sleep life____

Please complete both sides

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Have you **ever** been in an automobile accident? Past Year Past 5 years Over 5 years Never
LIST ACCIDENTS, FALLS, ETC. ______________________________

____

____

ANY **CHIROPRACTOR** CONSULTED IN THE PAST? Name: ______________
Dates consulted: ______________ For what problem? ______________

Other health Problems: ______ ______ ______ ______
Please list date and location of any **CAT scan/MRI/X-rays** ______________

What **surgery** has been done? (For anything) ______________

______________ ______________

DRUGS YOU NOW TAKE/Dosage______________ ______________

______ ______ ______ ______

Allergies to Medications: ______________
Prior Hospitalizations Date/Hospital/Reason: ______________

Social History

Exercise How Often______x/week What Type: ______ ______ ______
Marital Status (circle) Single Married Widow(er) Divorce Separated
Lives (circle) Alone W/Spouse W/Children W/__________
Smoking Status (circle) Never Former Current (How Often) __________
Alcohol (circle) None Casual Moderate Heavy Beer Wine Liquor
Caffeine ( ) No ( ) Yes, How much per day?______________
Drug Use (circle) None Recreational User Addiction ______________

FAMILY HISTORY: (*for example: Cancer, Diabetes, Heart Problems, Back or Neck Problems)*
Father: ______________
Mother:______________
Brother(s): ______________
Sister(s): ______________

INSURANCE INFORMATION: (Please Print)
Insurance Company: ______________
Relationship to Subscriber: Self Spouse Son Daughter
Subscriber's Name: ______________ Birthdate __________
ID #______________
GROUP NUMBER: ______________
Subscriber's Address: (Street, City, State, Zip) ______________
Subscriber's Place Of Employment ______________

Primary Care Physician: ______________ Date Last seen? __________
Phone ______________ Fax ______________

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

Signature ______________(seal) **Social Security#**______________ **Date** __________

Please complete both sides