APPLICATION FOR CARE AT CORRECTIVE CARE CHIROPRACTIC **Adult** (CCC)

PATIENT INFORMATION

Name: _____Birth Date: ____/____/____ Age: _____ ☐ Male ☐ Female

Address: _____City: _____State: _____ Zip: _____

E-mail Address: _____ Home Phone: _____

Mobile Phone: _____ Work Phone: _____Fax: _____

Social Security #: _____Driver's License #: _____

Employer: _____ Occupation: _____

Name of Spouse: _____ Occupation: _____

Names and Ages of your children: _____

_____

Who referred you to our clinic? :_____

HISTORY OF COMPLAINT

Please identify if you came to this office, not as a result of a complaint, but for wellness care by completing the following:
Your Goals of Wellness Care:

_____

Please identify, if any complaints, injury or illnesses that brought you to this office:

_____

When did these problem(s) begin? _____ is your problem(s) the result of ANY type of accident. ☐ Yes ☐ No

If yes identify type: ☐Auto ☐Work ☐ Home ☐Other (*please explain*):_____

Date of Accident _____Have you suffered with any of this or a similar problem(s) in the past? ❑ No ❑ Yes

If yes, When_____

Please state what type of treatment you have tried for this problem(s):

_____

Who provided it: _____**When?** _____

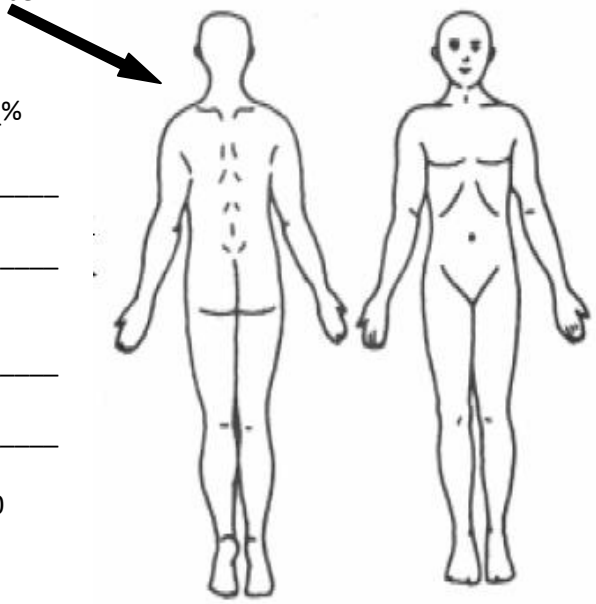
What were the results? ☐ Favorable ☐ Unfavorable→ please explain:

_____

Are you currently taking any medications? PLEASE LIST:

_____

***PLEASE MARK** the areas on the Diagram with the following letters to describe your symptoms: **R=Radiating B=Burning D=Dull A=Aching S=Sharp/Stabbing T=Tingling N=Numbness**



What percentages of the day do you experience symptoms: _____%

What relieves your symptom(s)?

_____

What makes them feel worse?

_____

Have you had previous chiropractic care? ☐ Yes ☐ No

Name of previous Chiropractor:

_____

What were the results?

_____

On a scale of 1 to 10 with 10 being the worst pain and 0 being no pain,
Rate how you feel today ***(Circle the #)*:** 0 – 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

PAST HISTORY

If you have ever been diagnosed with any of the following conditions please indicate with a

P for in the **Past**, **C** for **Currently** have and **N** for **Never** have had a**:**

[ ] Disability [ ] Broken Bone [ ] Fracture [ ] Dislocations [ ] Tumors [ ] Diabetes
[ ] Heart Attack [ ] Rheumatoid Arthritis [ ] Osteo Arthritis [ ] Cerebral Vascular
[ ] Other serious conditions:

_____

PLEASE, identify ALL PAST and any **CURRENT** conditions you feel may be contributing your present problem:

_____

SOCIAL HISTORY

1. Smoking: ❑cigars ❑ pipe ❑ cigarette → How often? ❑ Daily ❑ Weekends ❑Occasionally ❑ Never
2. Alcoholic Beverage: consumption occurs → ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
3. Recreational Drug use: ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never

FAMILY HISTORY:

1. Does anyone in your family suffer with the same condition(s) you currently have? ❑ **No** ❑ **Yes, if yes whom**: ❑ grandmother ❑ grandfather ❑ mother ❑ father ❑ sister(s)
❑ brother(s) ❑ son(s) ❑ daughter(s)
Have they ever been treated for their condition? ❑ No ❑ Yes ❑ I don't know
2. Any other hereditary conditions the doctor should be aware of. ❑ No ❑Yes: _____

_____

I hereby authorize payment to be made directly to Corrective Care Chiropractic for all benefits which may be due and payable under insurance coverage for the above named patient. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments. I further acknowledge that this assignment of benefits does not in any way relieve me of liability and that I will remain financially responsible to Corrective Care Chiropractic.

❑I request the clinic to submit claims to this insurance company:

_____.

Please provide your insurance card to us for copying. We will determine eligibility

.

_____ _____

Patient or Authorized Person's Signature **Date**

CONSENT TO TREAT A MINOR

MINOR PATIENT'S NAME: _____

The risks associated with exposure to ionization, and spinal adjustments have been explained to me to my complete satisfaction, and I have conveyed my understanding of these risks to the doctor, and after careful consideration I do hereby request, and authorize Corrective Care Chiropractic to perform imaging studies, and chiropractic adjustments, to my minor child, for whom I have the legal right to select, and authorize health care services on behalf of.

☐ Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse /former spouse or other guardian is not required. If my authority to so select and authorize this care should change in any way I will immediately notify this office.

_____ _____

Parent /Legal Guardian Date