APPLICATION FOR TREATMENT

Date: _____

Please check the type of care desired: ☐ **Temporary Relief** ☐ **Lasting Correction**

☐ **Check here if you want the Doctor to recommend the best type of care for you.**

NAME: _____ DATE OF BIRTH: _____ M F

ADDRESS: _____ SOCIAL SECURITY NO: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE: _____ CELL PHONE: _____

EMAIL: _____

Check if you are: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Name of Husband or Wife: _____ Age of Children: _____

EMPLOYER: _____

Employer's address: _____ Work Phone _____

Spouse's Employer: _____

Employer's address: _____ Work Phone _____

Your days off: _____

Who is responsible for your bill? ☐ Self ☐ Spouse ☐ Employer ☐ Insurance ☐ Other _____

How payment will be made:

_____ Cash
_____ Check
_____ Credit Card

Type of Insurance

_____ Workers' Comp.
_____ Health Insurance
_____ Automobile Ins. Policy

_____ Care Credit

NAME OF INS. COMPANY AND ADDRESS: _____

(Not at same address) I give Kostas Chiropractic Clinics permission to contact the person below on my behalf.

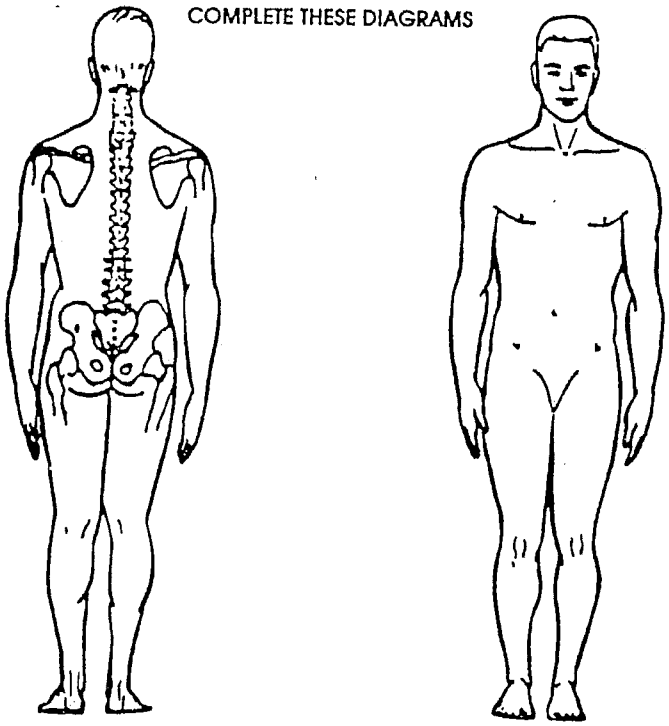
Name of nearest relative: _____ Relation _____

Home Phone: _____ Work: _____

Address: _____ City _____ State _____ Zip _____

If you are in pain, please mark the exact location of you pain on the diagram below. Also describe the type and frequency of you pain, as well as any activity, which brings on or aggravates the pain. For example, dull, sharp, constant, off & on, when standing, when sitting, etc., etc.

COMPLETE THESE DIAGRAMS



MAJOR COMPLAINTS

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

PLEASE LIST HEIGHT AND WEIGHT BELOW

Height: _____ Weight: _____

How did this condition develop? (What caused it? How did it start?) _____

When was the very fist time you were aware of this problem? _____

Have you ever had this problem of 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 is anything you do that makes your condition worse? _____

How has this condition affected your life?

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 [] Only this one

ANY ACCIDENT, FALL, ETC. THAT MIGHT HAVE CAUSED YOUR PROBLEM _____

Are you pregnant? ☐ Yes ☐ No

List any medications you are currently taken _____

ANY CHIROPRACTOR CONSULTED IN THE PAST?

Name: _____

Dates consulted: _____ for what problem? _____

IF YOURS IS AN ACCIDENTAL INJURY, PLEASE COMPLETE THE FOLLOWING QUESTION

Date of accident _____ Hour: ____AM ____PM Location: _____

How did accident occur? ☐ Auto Collision ☐ On-the-Job Injury ☐ Other _____

If not an auto collision, please describe the circumstances: _____

Did you report the injury to your foreman employer? ☐ Yes ☐ No

Did he (they) recommend care at our office? ☐ Yes ☐ No

If auto accident, where you ☐ Driver? ☐ Passenger? ☐ Pedestrian?

If auto collision, where you struck from ☐ Behind? ☐ Right Side? ☐ Left Side? ☐ Front? ☐ Auto was parked

Did your car strike the other(s) involved? ☐ Yes ☐ No; Or did the other car strike yours? ☐ Yes ☐ No ☐ Undetermined

As a result of the accident, were traffic citation issued to you? ☐ Yes ☐ No To the driver of the other car? ☐ Yes ☐ No

To the driver of your car? ☐ Yes ☐ No; List the extent of the injuries as you know them: _____

_____ did you require post-accident hospitalization? ☐ Yes ☐ No

CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:

☐ Headache	☐ Irritability	☐ Numbness in Toes	☐ Face Flushed	☐ Feet Cold
☐ Neck Pain	☐ Chest Pain	☐ Shortness of Breath	☐ Buzzing in Ears	☐ Hands Cold
☐ Neck Stiff	☐ Dizziness	☐ Fatigue	☐ Loss of Balance	☐ Stomach Upset
☐ Sleeping Problem	☐ Head seems too heavy	☐ Depression	☐ Fainting Spell	☐ Constipation
☐ Back Pain	☐ Pins & Needles in Arms	☐ Light bothers Eyes	☐ Loss of Smell	☐ Cold Sweats
☐ Nervousness	☐ Pins & Needles in Legs	☐ Loss of Memory	☐ Loss of Taste	☐Fever
☐ Tension	☐ Numbness in Fingers	☐ Ears Ring	☐ Diarrhea	☐ _____

Symptoms other than above: _____

Have you lost any days of work? ☐ YES ☐ NO Dates: _____

Name of your Insurance Company involved: _____

Name of your Insurance Company of person responsible for injuries: _____

Have you been contacted by an Insurance Adjuster or Company Representative regarding this claim? ☐ Yes ☐ No

Do you have an attorney who has advised you in this case? ☐ Yes ☐ No Name: _____

Address of attorney: _____ Phone No. _____

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: _____ Date: _____

GENERAL MEDICAL HISTORY

Y N Asthma
Y N Kidney disease
Y N Tuberculosis
Y N Diabetes # of years ____
Y N Insulin dosage___# of years____
Y N Migraines
Y N Psychiatric disorder
Y N Nervous disorder
Y N High Blood Pressure
Y N (women) are you pregnant?
Y N Anemia
Y N Confinement by illness/injury?
Y N Permanent defect for illness/injury?

Y N Head or Spinal Injury
Y N Seizures, Convulsions
Y N Cancer
Y N Thyroid disease
Y N Temporal arthritis
Y N Arthritis
Y N Carotid artery disease
Y N Heart disease
Y N Ulcer
Y N Stroke
Y N HIV
Y N Any other disease

Other Health problems or surgeries: _____
List all currant medications you are taking (including birth control pulls, Hormone replacement or over the counter medications):_____
_____
List Medications or other items you are allergic to: _____
_____

FAMILY HISTORY

Has anyone in your family (blood relative) had any of the following in the past?

Y N Glaucoma
Y N Cataracts
Y N Corneal disease
Y N Macular degeneration
Y N Retinitis pigmentosa
Y N Cancer, Radiation and/ or Chemo
Y N Other eye problems _____

Y N Diabetes
Y N Heart disease
Y N Diabetic retinopathy
Y N Retinal detachment
Y N Stroke

SOCIAL HISTORY

Use of alcohol Never ___ Rarely___ Moderate___ Daily___
Use of tobacco Never___ Rarely__ _Moderate___Dailey___
Use of drugs Never___ Rarely___ Moderate___ Daily___
Excessive exposure at work or home to: Fumes___Dust___Solvents___
Air borne particles___Noise___

ACCIDENTAL INJURIES

Y N Ambulance
Y N Emergency Room
Y N Air bag

PLEASE BRING POLICE REPORT AS SOON AS POSIBLE